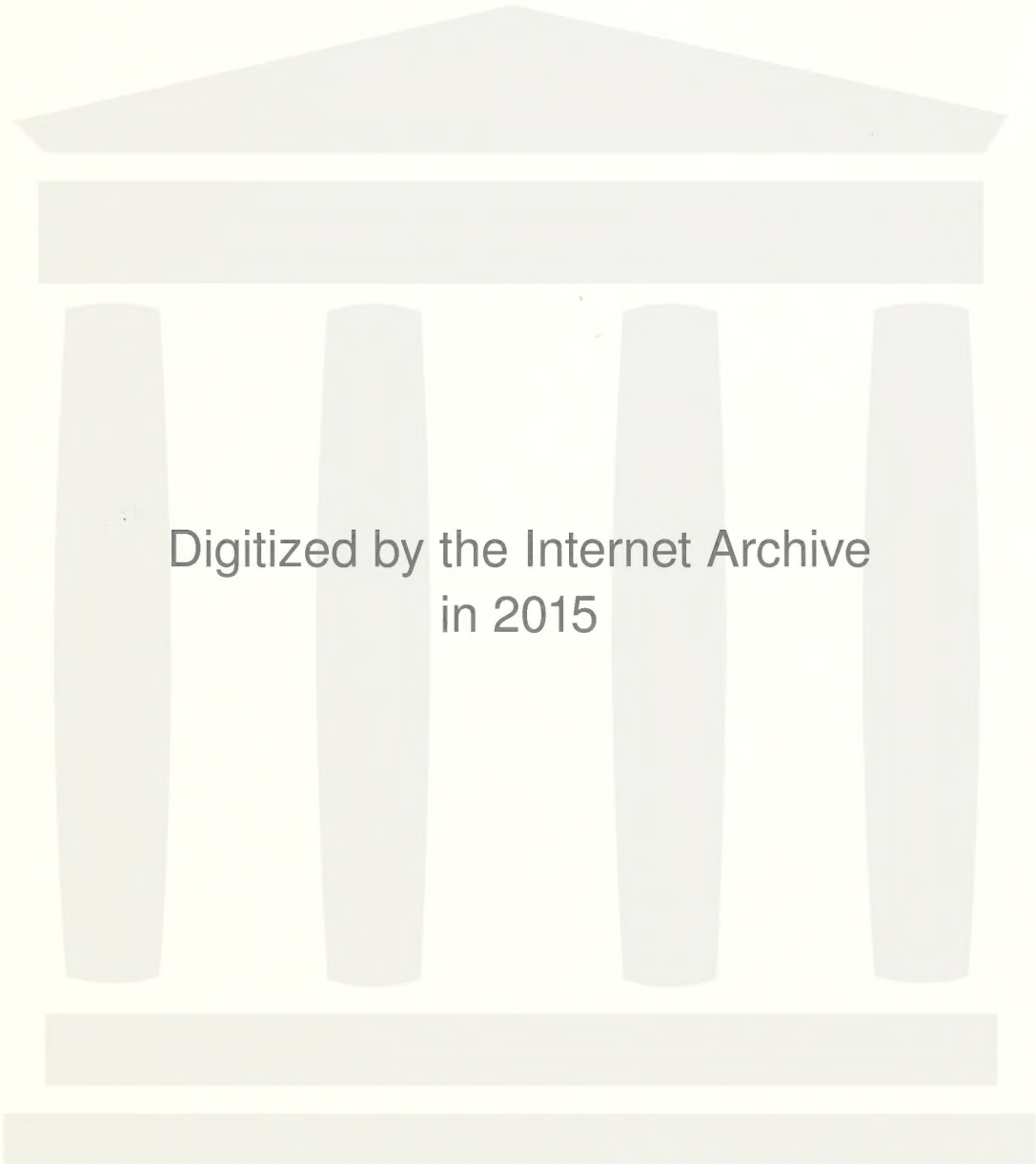
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INDIANA MEDICINE

The Journal of the Indiana State Medical Association

January/February 1993 Vol. 86, No. 1

HEALTH CARE TOPS LEGISLATIVE AGENDA



William H. Beeson, M.D.,-President
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The Journal of the Indiana State Medical Association

January/February 1993 **Vol. 86, No. 1**

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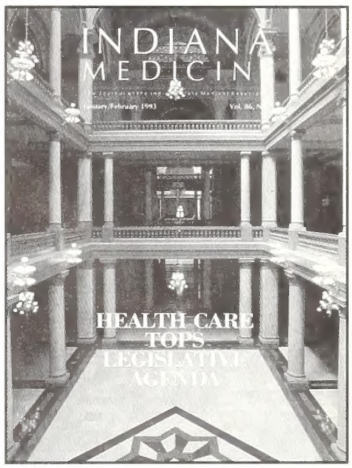
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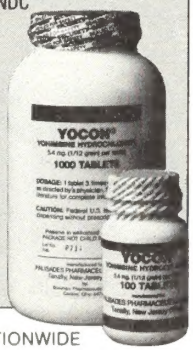
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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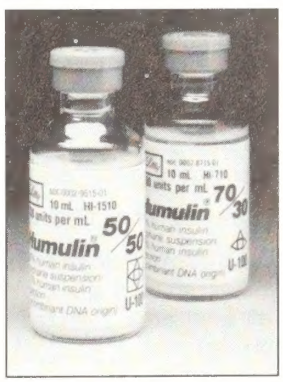
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ISMA members invited to 'Medicine Day' at the statehouse

The Indiana State Medical Association will sponsor its second annual "Medicine Day" at the Indiana Statehouse Wed., Jan. 27. The day will begin with a continental breakfast from 8:30 a.m. to 9:30 a.m. at the Hyatt Regency Hotel in downtown Indianapolis. Physicians will then visit the statehouse to discuss important health care issues with their legislators until 11:30 a.m. A lunch for physicians and legislators will be available from noon to 1 p.m. at the Hyatt.

All ISMA members are encouraged to attend. To register for "Medicine Day" events, call Debbie Warner at the ISMA, (317) 261-2060 or 1-800-257-4762.

ISMA/IMPAC legislative reception set for Jan. 27

ISMA members are invited to "Escape to the Islands" during the annual ISMA/IMPAC Legislative Reception set for Wed., Jan. 27, from 6 to 8:30 p.m. at the Westin Hotel in downtown Indianapolis. The reception will give ISMA members a chance to meet legislators and discuss areas of concern. A steel drum band will perform at the event, which features a Caribbean theme. For details, call Susan Grant, (317) 261-2060 or 1-800-257-4762.

Supplements available to vaccine information pamphlet

Printed copies of a one-page supplement to the 1991 pamphlet *Diphtheria, Tetanus and Pertussis: What You Need to Know* are now available from CORPrint of Indianapolis. Physicians who administer immunizations to children are required to provide the one-page supplement to the child's parent or guardian under the Childhood Vaccine Injury Act of 1986. The Indiana State Department of Health mailed one copy of the camera-ready supplement to every physician last October.

To order, call CORPrint at (317) 255-2178. The supplement is $10 per 100 copies, plus tax and shipping.

'Hold harmless' clauses may put liability coverage at risk

Physicians who are offered a contract containing a "hold harmless" clause should ask that it be deleted because their professional liability insurance carrier may not cover them. Physicians should insist on contract language that makes each party responsible for his or her own actions.

"Hold harmless" clauses are agreements in which one party agrees to hold the second party harmless by promising to pay the losses, damages, expenses, costs or attorney fees that the second party may incur as a result of being sued or included in litigation because of the negligent act of the first party.

Physicians should be aware that most professional liability insurance policies will not cover them for costs incurred because of a "hold harmless" clause.

If you have questions, call Ron Dyer at the ISMA. ❑

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letter to the editor

I read with interest the letter to the editor by Dr. Douglas Morrell of Rushville (November/December 1992 INDIANA MEDICINE) and certainly agree with his concerns about the cost of following Occupational Safety and Health Administration (OSHA) regulations.

As medical consultant to Indianapolis Physical Therapy and Sports Medicine, I reviewed the cost of the OSHA regulations concerning bloodborne pathogens, which involved informing all the employees and, for the therapist, providing the hepatitis vaccination. This amounts essentially to the cost of one-third of a therapist for a year and, of course, does not bring in any income to offset that cost.

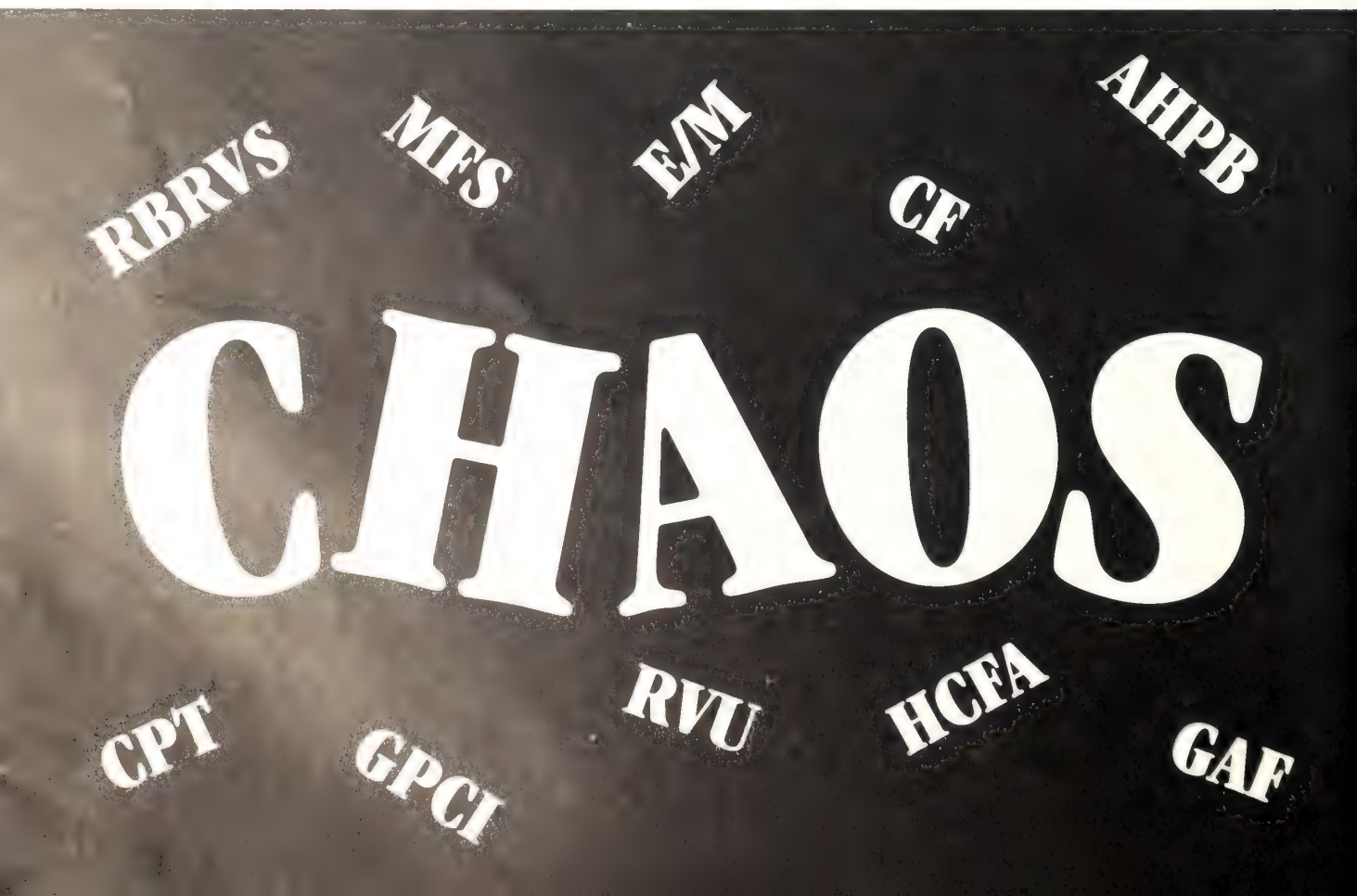
I would suggest that we all contact our congressmen, and as long as the regulations are forced upon us, the payment for the cost could be best handled as a tax credit. It would certainly be an aggravation, but making it an expense of business really is not very practical and may put people out of work as well as cutting down the family physician's and solo doctor's ability to practice, particularly in the outlying communities. ❑

F. Robert Brueckmann, M.D.
Indianapolis

Letters to the editor

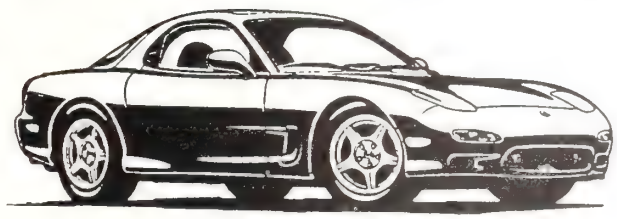
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Health economist stresses

Bob Carlson
Indianapolis



Health care is second only to the economy as the biggest worry for Americans, according to a recent poll. That's not surprising, considering that approximately 37 million Americans don't have any medical insurance and that the nation's total annual expenditure on health care is more than $800 billion, more than education and defense combined, and rising.

Medicaid, designed to fill the gap for low-income Americans, accounts for expenditures of approximately $90 billion annually. The costs of Medicaid are shared by states and the federal government. But because Medicaid reimbursements have been steadily reduced, in many states below the cost of delivering care, some doctors and hospitals are turning away Medicaid patients.

For an overview of current issues in Medicaid, INDIANA MEDICINE talked with Deborah A. Freund, Ph.D. She is director of the Bowen Research Center at Indiana University, where she is also professor of public affairs with a specialty in health economics and associate dean of the School of Public and Environmental Affairs.

She received her M.A., M.P.H. and doctoral degrees at the University of Michigan. Her career has included managing the ambulatory care and surgery departments of a major teaching hospital and positions in federal and state government. From 1986 to 1989, she was chairman of the Medical Care Section of the American Public Health Association. She is currently chairman of the board of the Association of University Programs in Health Administration and a member of the board of directors of the Association for Health Services Research.

Dr. Freund has received many professional honors for her contributions in administration, policy and research. She is widely published and is particularly noted for her research on Medicaid case management.

INDIANA MEDICINE: **Many social phenomena, such as women who drink and smoke during pregnancy, risking the health of their children, and the problem of violence on our streets, drive up the cost of health care. What are your thoughts on solutions to these social problems that would help hold down health care costs?**

Freund: Well, let me try to answer that broadly by saying that one of the things that many advocates stress would be payment for preventive services, greater payment for counseling on the part of family physicians in primary care, doctors in counseling individuals not to smoke and things like that.

From the perspective of a health economist, such as I am, one problem that you have with doing that is something that has a really funny title. It's called moral hazard. Under moral hazard, we believe that if you subsidize something through the insurance system, people often use more of it than is necessary. When you put that together with the basic model of indemnity insurance, which suggests that you only insure against events that would result in a high economic loss to an individual, if it were to occur; or an event that is really unlikely to occur, that the individual can

coordination of care

influence and control, you then see why most health insurance policies don't pay for counseling, because it's not a high loss and it's under an individual's control, and why they don't pay for prevention. So I don't believe that the standard insurance system will ever be used to try and hold these problems down.

One of the things that I believe is a problem here is the lack of coordination between medical care programs and other social programs. We tend to see health care costs being higher and we tend to see solutions coming from tinkering with the medical care delivery system. But I don't think the medical care delivery system can get rid of social problems that may underlie drinking and smoking, such as a poor household situation, poor housing situation, lack of family support and so on. So the bottom line is, we can't do everything through the medical care system to tackle these problems.

Let me give you another example of a problem that is closely related along the same public policy lines. We know that



people who are poor frequently lack access to good prenatal care. And it is believed if they had more prenatal care, they would give birth to healthier babies who weighed more and would not have to be hospitalized in neonatal intensive care units, which can cost $100,000 per hospitalization.

> *"But I don't think the medical care delivery system can get rid of social problems that may underlie drinking and smoking, such as a poor household situation, poor housing situation, lack of family support and so on."*

It's believed that if moms got more prenatal care and took better care of themselves, we could save money. Looking at it the converse way and linking it to your problem, it's that they engage in poor nutritional practices that can lead to lower birth weights, which can lead to higher health care costs.

I think it's perfectly obvious that access to prenatal services alone won't get rid of the problem and won't touch it. And that it isn't really solely the fault of the health care delivery system that we have mothers who give birth to kids who die or are born prematurely or don't weigh enough. Certainly the health care delivery system can do a lot. But we don't have good coordination between it and other social programs to provide greater nutrition, better housing and social support. Until we do that, I don't think we can come up with a comprehensive solution.

INDIANA MEDICINE: **Why hasn't Indiana enacted a Medicaid gatekeeper concept? A 1986 Indiana law required the Department of Public Welfare to seek a waiver, but it has not done so. Federal law says Medicaid recipients have the right to choose their own providers, but states can seek waivers to change this.**

Freund: If you're looking at why some states have chosen not to get into the gatekeeper concept, I can give you some of their general reasons. Let me put it in context by indicating that about 40 out of 50 states do have a Medicaid waiver to mandatorily or voluntarily enroll Medicaid beneficiaries in gatekeeper programs. When you look at the studies that my team of investigators has done at Indiana in conjunction with people at the Medical College of Virginia, the University of North Carolina and Research Triangle Institute, you find that gatekeeper programs save 2% to 5% in program dollars, which is a significant amount of money but not perhaps as much as individuals would want.

When you look at that as a benefit, people are skeptical what you get for it. The studies we've done of quality of care have shown no improvements but no decrements in quality. What we have found is a resounding benefit. We have found that access to

primary care is increased and that what we call concentration of care is increased. There's a large number of Medicaid beneficiaries who, because they have no usual primary care physician to go to or for other social problems, shop around for physicians. When you have them enroll in a gatekeeper concept, they do go to one physician more often. They have greater continuity of care. And they use the emergency room 45% less. So there are many benefits.

Many states are concerned that the reduction in cost, the reduction in emergency room use, the greater concentration of care, but without proven, real, demonstrable benefits in improving birth weight or in the management of other relevant chronic conditions, sways them that it isn't worth it for a program that is often viewed, at least by some, as unpopular. What you find when you do surveys of Medicaid beneficiaries in gatekeeper plans is that they like it a lot. But before they get in, many people are afraid that you're taking away their choice of physician, and that's a freedom that they're hesitant to give up. So, many states don't want to go through the hassle of implementing a program and getting in place the infrastructure for doing so when they know that many patients will feel that it is counter to their interests.

INDIANA MEDICINE: **The federal government has to approve every state Medicaid program, which includes mandatory services and 31 optional services, such as optometric and podiatric and chiropractic services. Indiana offers 28 of those optional services. However, at the same time only a very small minority of the Medicaid recipients, usually the poorest of the poor, are eligible for these optional services. Would it be prudent to instead reduce the number of optional services and increase the number of people eligible for them?**

Freund: You're getting into a real thicket, for a variety of reasons. To put it into perspective, Indiana's Medicaid program is one of the hardest to qualify for in the United States, in terms of the income standard. But once you get in it, it has a richer benefit package and has payment rates that are higher than almost any other state. My physician friends look at me with an incredulous look when I say that, because the payment rates aren't wonderful here, but they are almost comparable to Medicare. And you can't say that for many other states.

The reason that it's really hard to answer that question is that I think we know surprisingly little about what we get for the delivery of certain services. We can all think of people that we know who have clearly benefited from service X or Y. But to answer your question forthrightly requires really knowing what benefits the average Medicaid beneficiary in terms of outcomes of care. By outcomes of care I mean, does an individual service you provide, or battery of services, restore somebody to functional status quicker than if they didn't have it? [Does the service] return them to work and get them off Medicaid quicker? In the case of Medicaid beneficiaries who are elderly, if they have joint replacement or certain types of heart surgery, are they able to walk farther with less pain than before? The answer is, we don't know. And until we know, I think it's arbitrary to point a nasty finger at some services and say yes, cut some and don't cut others.

The state of Oregon proposed a rather unique approach to this, where they got together a consensus panel of physicians, as well as consumers, that is, Medicaid beneficiaries and other people, to prioritize the list of most needed services. That's probably as good a way of doing it as asking me. But it still is somewhat arbitrary, in that we don't have good research to guide us.

Inevitably, the question is right on target. We can't continue to see Medicaid take all of our discretionary dollars and have entitlement programs grow quicker than any other program is growing from the point of view of the state or the federal government. So we're going to have to do something. It's very difficult to say what to cut. Most people would say cut something so that more people benefit. But I think that you could be here debating until two weeks from now and not have any good method for doing that.

INDIANA MEDICINE: **Some of our physicians here in Indiana are saying that they are reducing the number of Medicaid patients that they will see, not because of the reimbursement amounts but because of the administrative hassles involved. What do you think can be done to ease that hassle factor, without compromising the integrity of the program or sacrificing access to care?**

Freund: There's been a lot of

research on hassle factors. Indiana physicians aren't alone. Most physicians in the United States answer similarly, and they're absolutely correct. The reason we have a morass of hassles is because there's tremendous bureaucracy associated with any claims system, for reasons of cost control and utilization review.

We're in this mess for a whole variety of reasons that are really complicated. Number one, you want to get cost control, so you're always looking for a service or two that are unnecessary. To determine medical necessity, you have to fill out a claims form and send it in. And it has to meet a special edit in the computer. If we weren't so concerned about medical necessity, or lack of it, we wouldn't be so concerned about everything being filled out on that form absolutely correctly. So things are just sent back when there's human error in filling out a form.

If you look at the bottom line, what you see is that most physicians are really trying very hard to do right by their patients. And what you see is a small group of physicians who ruin it for everybody else by abusing the system, which then necessitates putting in place a tremendous amount of bureaucracy to look for what we're getting for our dollars. I think it would be better to be strong in really reviewing the practices of those individuals and deregulating the lives of other physicians.

By having it appear that I'm pointing a nasty finger at a small group of physicians that I don't know, I want to just put it in perspective by saying that in every profession there are people who do it well and people who do it poorly. And usually the people who do it poorly are a small minority of individuals. So medicine isn't alone. There are economists that make irresponsible statements all the time. I believe they are a minority of people, but they wreck our reputations also. So I think this is a problem that all of the professions have, and if we found a way to better police ourselves, we could get out of great government bureaucracy.

> ***"The reason we have a morass of hassles is because there's tremendous bureaucracy associated with any claims system, for reasons of cost control and utilization review."***

INDIANA MEDICINE: **For the medical profession to police itself?**

Freund: I think if the medical profession could police itself and make a partnership with Medicaid programs to really do something about those individuals who were offenders, we would find that we could lift the tremendous administrative and regulatory burden off the backs of the 98% to 99% of physicians who are doing a good, honest job. But we have in place a system whereby we hate to police each other, and the Medicaid program has little teeth to do anything about those individuals and so it puts in place a tremendous bureaucracy that scrutinizes, attempts to scrutinize through the claims process, everything that everybody does, and it's sort of silly.

INDIANA MEDICINE: **Let me go back to the first question and your comment about the varieties of poor health practices, poor lifestyle choices, and that one cause is insufficient coordination between the medical profession and other social programs. Can you suggest any avenues that perhaps you've looked at or have investigated where that might become practical?**

Freund: One of the things that I've been advocating for a long time is the notion of one-stop shopping. Instead of requiring people to go to 10 different offices if they want to get food stamps and they want to get Medicaid and they want to get low-income housing and they want a teen pregnancy program for their kid and they want job training, they have one-stop shopping in their neighborhoods. And we certainly have the chance here in Indianapolis to do some innovative things, because I know Steve Goldsmith is keenly interested in this. What frequently happens now is not only do you have to go to 10 places, but you have to drive downtown, and people sometimes don't have the carfare, they can't get a ride, the offices aren't open at convenient times.

The idea is if you can coordinate it and put it in their neighborhood, so they can walk, so moms can drop off their kids while they're getting job training,

we might have a real crack at doing something. But it requires much greater administrative coordination than we have. It requires getting over the turf battles that any agency naturally has, just the way other professional groups have, or that people do in life. And so it's a tall order, but I think it's doable.

INDIANA MEDICINE: **Have employer coalitions and managed care failed?**

Freund: Employers have gone into managed care with the hopes of saving 30% in health care costs or getting real cuts in premiums. I think it should be understood that it is unrealistic to ever think we're going to have cuts in health care premiums. We might be able to slow the rate of growth. But to cut premiums for a family of four, which are now an average of almost $4,000 a year, to $3,500 is not something we're going to see in our lifetime.

I believe that, relative to expectations, managed care hasn't delivered that result. That doesn't mean that it hasn't arrested the rate of growth. It doesn't mean that people aren't happy. And it doesn't mean that it isn't the way to go. But it does mean that it isn't the great panacea for taking care of our health care cost problems.

We have very little managed care in this state in comparison to other states. And my perception is that, as much as we think it's competitive and cut-throat for the practice of medicine in a city like Indianapolis, it isn't, if you compare us to what goes on in New York, Boston, San Francisco, Chicago or Minneapolis. So, if we wonder what is going to be the impact of managed care in Indiana, I can only say that the experience we have now may not be predictive of the future. ❑

This interview was conducted by Bob Carlson, a health care communications consultant in Indianapolis.

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Improving preschool-aged vaccination coverage:

Not business as usual

Mary Ann Sprauer, M.D., M.P.H.
Indianapolis

Age-appropriate vaccination provides the maximum protection against vaccine-preventable diseases (VPDs) at the earliest time in children's lives, when they are most vulnerable to infection with and complications from such illnesses. The Committee on Infectious Diseases of the American Academy of Pediatrics and the Immunization Practices Advisory Committee both recommend that complete vaccination coverage – four doses of diphtheria-tetanus-pertussis (DTP), three doses of oral polio (OPV), one dose of measles-mumps-rubella (MMR), three or four doses of *Haemophilus influenzae* type b (Hib) and three doses of hepatitis B vaccines – should be received by all children by 2 years of age.

Indiana accords high priority to achieving 90% age-appropriate vaccination coverage among preschool-aged children (those younger than two years) by the year 2000. Accordingly, from March through June 1992, the Indiana State Department of Health (ISDH) convened a statewide Immunization Task Force, comprised of more than 50 representatives from public and private vaccine delivery systems, health professional organizations, state and local agencies, volunteer and community-based organizations, the private business sector, community leaders and educators. The task force presented and reviewed information on VPD incidence, vaccination coverage and causes for failure to achieve 90% vaccination coverage among preschool-aged children and made recommendations to improve coverage. The Indiana Immunization Action Plan (IAP), in the form of a grant proposal to the Centers for Disease Control (CDC), represents task force findings, recommendations and a series of program objectives and action steps to address this challenge. This is the first time federal funding has been made available to improve vaccine delivery infrastructure.

Vaccine-preventable diseases

Like other areas of the country, Indiana experienced measles outbreaks during 1989 and 1990. Compared to a median of 39 measles cases from 1984 to 1988, there were 115 and 412 cases reported during 1989 and 1990, respectively. Age-specific rates for measles and other VPDs are unacceptably high among infants and young children *(Table 1)*.

Complications due to measles include otitis media, pneumonia, encephalopathy and death. About 25% of complications in 1989 and 1990 occurred among children aged 2 years or under. Hospitalization rates were highest for those aged 1 year and under, and over 15 years of age. In 1989, three (18%) children aged 1 to 4 years with measles had documentation of vaccination; in 1990, five (8%) had documentation of vaccination.

Pertussis also accounts for significant morbidity in Indiana, especially among children under 1 year of age. Among all pertussis cases from 1989 to 1991, 35% to 53% occurred among children aged under 1 year; 63% to 96% of these were hospitalized. In 1991, of 48 pertussis cases aged three months or more with known vaccination status, 19 (40%) were age-appropriately vaccinated.

Vaccination coverage

Data about vaccination coverage of 2-year-olds in Indiana are available from three sources: retrospective kindergarten surveys; vaccination audits of public health clinics; and doses administered data.

The 1990-91 retrospective survey was conducted by reviewing 10% of vaccination records for current kindergarten students selected using modified stratified random sampling. Records were reviewed for DTP, OPV and MMR vaccination status at the time these children were 24 months old. Since the records were those of children currently in kindergarten, these data reflect vaccination coverage approximately three to four years previously. Data from this survey indicate that the overall vaccination coverage rate of 2-year-olds for Indiana was 53%. County-specific rates ranged from 28% to 100%.

The retrospective survey for school year 1991-92 was completed in April 1992, with a point estimate for overall coverage of 2-year-olds of 56%. Antigen-specific coverage rates in the 1990-91 and 1991-92 surveys were similar: DTP-4 – 56% and 59%; OPV-3 – 78% and 75%; and MMR – 76% in both years.

Accurate data about vaccina-

tion coverage among minority preschool-aged children are not available. However, data from the 1990-91 retrospective survey were examined to provide a surrogate measure of coverage among these children. Forty schools were surveyed in the five Indiana counties (Allen, Lake, Marion, St. Joseph and Vanderburgh) with the largest minority populations. Eleven of those schools had minority enrollments of 25% or more; all had coverage levels below the state coverage level of 53% (range 18% to 52%).

More current data about vaccination coverage in the public sector were obtained from Indiana's first audit of public health clinic records in 1991. In this survey, 25 randomly selected vaccination records from children aged 24 to 35 months, attending Indiana's 93 public health vaccination clinics, were reviewed for DTP, OPV and MMR vaccination status. The overall coverage rate identified was 61%; clinic-specific levels ranged from 0% to 96%. Antigen-specific coverage was 62% for DTP-4 and 84% for MMR.

Finally, data are available about antigen-specific vaccine doses administered by age gathered from monthly reports from all agencies administering public vaccine. From 1988 to 1991, total

Table 1

Age-specific rates* for certain vaccine-preventable diseases in Indiana, 1990-91

A. 1990

	Pertussis		Measles		*H. influenzae*+	
Age	No. cases	Rate	No. cases	Rate	No. cases	Rate
0-11 months	52	62.2	15	18	37	44.3
1-4 years	48	14.9	60	18.7	35	10.9
5-9 years	19	4.6	56	13.7	6	1.5
10-14 years	7	1.7	84	20.7	1	0.2
15-19 years	4	0.9	132	30.8	0	0
≥ 20 years	14	0.4	65	1.7	11	0.3
Total**	**147**	**2.7**	**412**	**7.4**	**95**	**1.7**

B. 1991

	Pertussis		Measles		*H. influenzae*++	
Age	No. cases	Rate	No. cases	Rate	No. cases	Rate
0-11 months	24	28.7	2	2.4	17	20.3
1-4 years	20	6.2	1	0.3	14	4.4
5-9 years	7	1.7	0	0	3	0.7
10-14 years	7	1.7	0	0	1	0.2
15-19 years	1	0.2	3	0.7	0	0
≥ 20 years	5	0.1	0	0	12	0.3
Total**	**66**	**1.2**	**6**	**0.1**	**48**	**0.9**

* = Rates per 100,000 (1990 census).
+ = Includes invasive and noninvasive disease.
** = Age unknown for three cases of pertussis and five cases of *H. influenzae* in 1990, and for two cases of pertussis and one case of *H. influenzae* in 1991.
++ = Includes sterile site isolates only.

Table 2

Guide to contraindications and precautions to immunizations

Vaccine	True contraindications & precautions	Not true (vaccines may be given)
General for all vaccines	Anaphylactic reaction to a vaccine contraindicates further doses of that vaccine	Mild to moderate local reaction (soreness, redness, swelling) after a dose of an injectable antigen
(DTP/DTaP, OPV, IPV, MMR, Hib, HBV)	Anaphylactic reaction to a vaccine constituent contraindicates the use of vaccines containing that substance	
	Moderate or severe illnesses with or without fever	Mild acute illness with or without low-grade fever
		Current antimicrobial therapy
		Convalescent phase of illness
		Prematurity (same dosage and indications as for normal, full-term infants)
		Recent exposure to an infectious disease
		History of penicillin or other nonspecific allergies or fact that relatives have such allergies
DTP/DTaP	Encephalopathy within 7 days of administration of previous dose of DTP	Temperature of < 40.5°C (105°F) after a previous dose of DTP
	Precautions* Fever of ≥ 40.5°C (105°F) within 48 hours after vaccination with a prior dose of DTP	Family history of convulsions**
	Collapse or shocklike state (hypotonic-hyporesponsive episode) within 48 hours of receiving a prior dose of DTP	Family history of sudden infant death syndrome
	Seizures within 3 days of receiving a prior dose of DTP (see footnote** regarding management of children with a personal history of seizures at any time)	Family history of an adverse event after DTP administration
	Persistent, inconsolable crying lasting ≥ 3 hours within 48 hours of receiving a prior dose of DTP	
OPV***	Infection with HIV or a household contact with HIV	Breast feeding
	Known altered immunodeficiency (hematologic and solid tumors; congenital immunodeficiency; and long-term immunosuppressive therapy)	Current antimicrobial therapy
	Immunodeficient household contact	Diarrhea
	Precaution* Pregnancy	

Table 2 continued

Guide to contraindications and precautions to immunizations

Vaccine	True contraindications & precautions	Not true (vaccines may be given)
IPV	Anaphylactic reaction to neomycin or streptomycin Precaution* Pregnancy	
MMR***	Anaphylactic reactions to egg ingestion and to neomycin Pregnancy Known altered immunodeficiency (hematologic and solid tumors, congenital immunodeficiency and long-term immunosuppressive therapy) Precaution* Recent (within 3 months) IG administration	Tuberculosis or positive PPD Simultaneous TB skin testing**** Breast feeding Pregnancy of mother of recipient Immunodeficient family member or household contact Infection with HIV Nonanaphylactic reactions to eggs or neomycin
Hib		
HBV		Pregnancy

* The events or conditions listed as precautions, although not contraindications, should be carefully reviewed. The benefits and risks of administering a specific vaccine to an individual under the circumstances should be considered. If the risks are believed to outweigh the benefits, the immunization should be withheld; if the benefits are believed to outweigh the risks (for example, during an outbreak or foreign travel) the immunization should be given. Whether and when to administer DTP to children with proven or suspected underlying neurologic disorders should be decided on an individual basis. It is prudent on theoretical grounds to avoid vaccinating pregnant women. However, if immediate protection against poliomyelitis is needed, OPV, not IPV, is recommended.

** Acetaminophen given before administering DTP and thereafter every four hours for 24 hours should be considered for children with a personal or with a family history of convulsions in siblings or parents.

*** There is a theoretical risk that the administration of multiple live virus vaccines (OPV & MMR) within 30 days of one another if not given on the same day will result in a suboptimal immune response. There are no data to substantiate this.

**** Measles vaccination may temporarily suppress tuberculin reactivity. If testing cannot be done the day of MMR vaccination, the test should be postponed for four to six weeks.

This information is based on the recommendations of the Immunization Practices Advisory Committee (ACIP) and those of the Committee on Infectious Diseases (Red Book Committee) of the the American Academy of Pediatrics (AAP). Sometimes these recommendations vary from those in the manufacturer's package inserts. For more information, providers should consult the published recommendations of the ACIP, the AAP, the AAFP and the manufacturer's package inserts.

Source: Standards for Pediatric Immunization Practices, 1992.

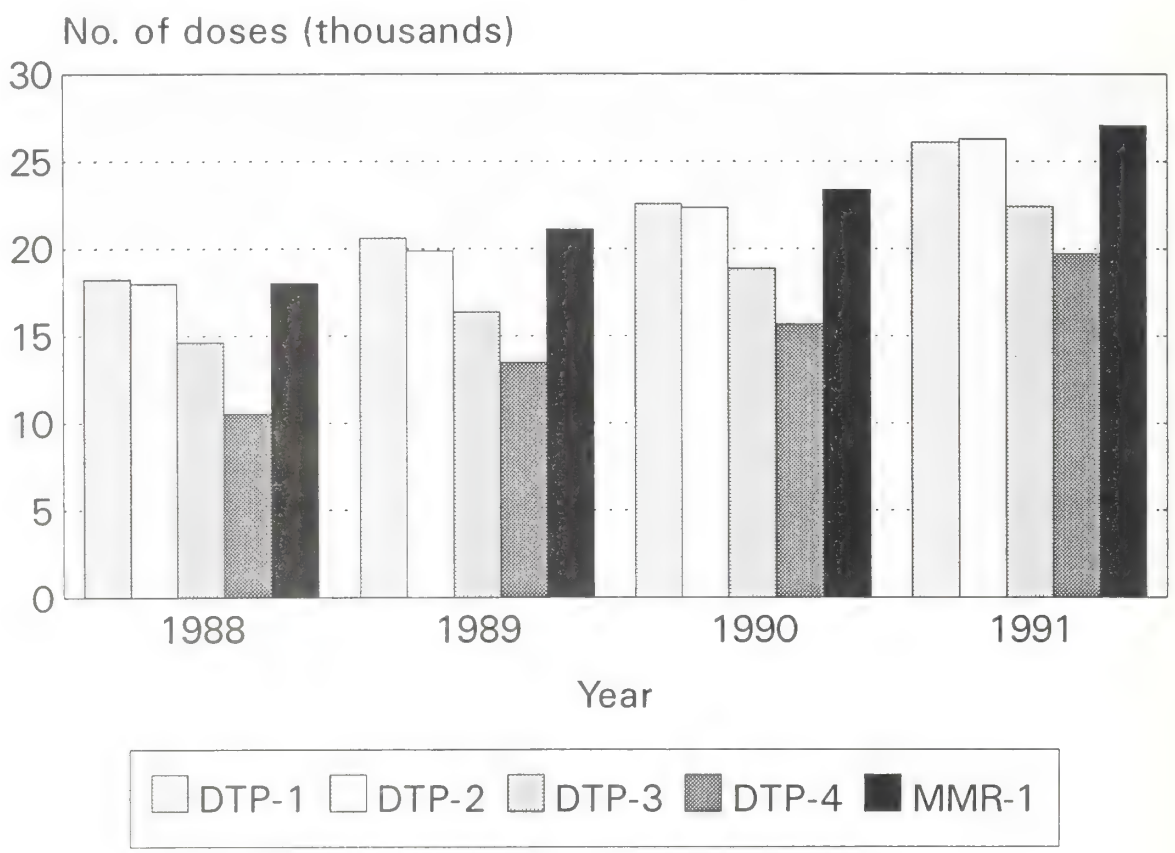
doses of DTP, OPV and MMR administered increased as follows: DTP – from 100,591 to 151,013; OPV – from 91,360 to 129,837; and MMR – from 31,040 to 71,343 (including the second MMR dose).

Doses-administered data also suggest that each year more children received DTP-4 before 2 years of age in the public sector; however, this does not mean that overall age-appropriate vaccination has improved. An increase in doses administered may be due to the myriad causes for children shifting from the private to the public vaccination sector, including cost and liability concerns among private providers, financial burdens related to the economy and access to health care and, in the future, increased financial demands due to new vaccines (*Haemophilus influenzae*, hepatitis B and acellular DTP) and added logistic complexity in using the federally mandated Vaccine Information Pamphlets.

Ideally, for every dose of DTP-1 administered, doses of

Figure

Age-specific* public sector doses administered of DTP-1, 2, 3, & 4, and MMR-1, by year, Indiana 1988-91



* DTP-1,2 & 3 administered to children aged 2-11 mths;
DTP-4 & MMR-1 administered to children aged 12-23 mths

DTP-2, 3 and 4 and MMR-1 should also be administered. Data on yearly vaccine- and age-specific doses administered are shown in the *Figure*. These data indicate drop-out from DTP-1 to DTP-4 consistently from 1988 to 1991 – an average of 0.6 doses of DTP-4 were administered for every dose of DTP-1. The ratio of MMR-1 to DTP-1 from 1988 through 1991 averaged 1.0. Comparing the ratios of MMR-1 and DTP-4 to DTP-1 indicates that simultaneous administration of these two vaccines could improve age-appropriate vaccination. Also, for every dose of MMR-1 administered between 1988 and 1991, an average of 0.6 doses of DTP-4 was administered. Since the 1991 clinic audit showed that overall, 84% of 2-year-old children had received MMR, it is possible that simultaneous vaccination with MMR, DTP-4, OPV-3 and Hib could increase vaccination coverage close to 84%.

In summary, although data suggest there has been some improvement in age-appropriate vaccination status of 2-year-old children in Indiana, they clearly demonstrate a remaining major problem: more than one-third of Indiana's preschool-aged children are not age-appropriately vaccinated by 2 years of age.

Why is vaccination coverage low?
Causes of low vaccination coverage can be divided into four categories: 1) missed opportunities; 2) barriers to vaccination; 3) inadequate access to care; and 4) lack of public awareness and demand for vaccination.[1]

Missed opportunities
There are three types of missed vaccination opportunities: 1) a child is seen by a health care provider for vaccination and all indicated vaccines are not administered at that visit (lack of simultaneous vaccination); 2) a child is seen by a health care provider for a non-vaccination visit and the child's vaccination status is not assessed and made current; and 3) a child has contact with a public assistance program (such as the Special Supplemental Food Program for Women, Infants and Children [WIC]) where vaccination services could be delivered, and those services are not provided.

To overcome missed opportunities, widespread adoption of simultaneous administration policies and formal integration and expansion of vaccination services in a variety of public programs will be necessary.

Barriers to vaccination
There are a variety of impediments to vaccination in both the public and private sectors. In public health vaccination clinics, barriers include requirements for appointments, physical examinations, individual physician orders, physician referral, enrollment in well-baby clinics and residency; financial obstacles; inadequate resources to provide sufficient staff, hours and locations for vaccination; cultural and language barriers; and failure to use reminder/recall and tracking systems to facilitate parents' efforts to ensure vaccination of their children.

In the private sector especially, financial barriers to vaccination exist when maximum financial reimbursement for vaccination services is not available. A 1990 national survey by the Health Insurance Association of America indicated the following percentages of enrollees covered for childhood vaccination: 47% in conventional plans; 65% in preferred provider organizations; 90% in point-of-service; 97% in an independent practice association health maintenance organization (HMO) model; and 99% in staff/group health maintenance organizations.[2] Similar data for Indiana are limited. However, in 1989, it was estimated that about 750,000 people had no health insurance. A 1990-91 ISDH-conducted parent survey showed that, of 1,983 patients in 88 local public health agencies, 281 (14%) received Medicaid, 40 (2%) had HMO benefits and 1,267 (64%) had health insurance, but most did not cover immunization services.

A 1990 ISDH survey of primary care physicians found that, of 1,100 physicians providing vaccination, 253 (23%) were considering stopping, primarily due to cost. A commonly expressed source of frustration by private health care providers on the task force was the difficulty of reconciling the goals of providing comprehensive care for all their patients regardless of ability to pay and the rising cost of vaccination.

Uniform adoption of the *Standards for Pediatric Immunization Practices* that call for removal of many of the barriers described above could help alleviate these obstacles to vaccination.

Access to care
Financial and logistic difficulties with vaccination services described above reflect similar problems with access to overall health care in Indiana. The ISDH Office of Public Health Research, using 1990 census data, estimated there are approximately 25,000 children

in Indiana under 5 years of age who lack health insurance and are below 200% of poverty, resulting in isolation from the health care system.

In the 1990 parent survey, 1,770 (90%) respondents stated they had a health care provider outside the vaccination clinic but were unable to receive vaccination for their children from these providers. The task force expressed concern about fragmentation of care and missed opportunities created when vaccination is provided in settings that do not provide comprehensive medical care, while acknowledging the pressing need to move forward with vaccination-focused efforts. Strategies resulting from these efforts should include the ultimate goal of providing comprehensive care whenever possible.

Inadequate public awareness

Data are limited regarding provision of vaccination information and education. Task force members cited our overall success in decreasing childhood VPDs, competing priorities, disenfranchisement, isolation from the health care system, lack of cultural appropriateness and unfounded fear of adverse events as barriers to parental awareness of the importance of age-appropriate vaccination. There is need for a variety of educational materials targeted to different audiences. Also needed is professional education for vaccine providers to increase their knowledge about vaccination and about the *Standards for Pediatric Immunization Practices.*

Summary

In summary, major areas of need include: 1) overcoming missed vaccination opportunities through simultaneous vaccination and formally integrating and expanding vaccination services in various public and other programs that serve preschool-aged children and their families; 2) overcoming barriers to vaccination through the following: adopting the *Standards for Pediatric Immunization Practices;* obtaining financial support for expansion of public vaccination services to target hard-to-reach populations; developing ways to optimize reimbursement for vaccination services in both the public and private sectors; establishing specific strategies to identify, inform and serve minority populations; and increasing utilization of recall/reminder and tracking systems; 3) including childhood vaccination services in plans to increase access to health care; and 4) developing and providing clear targeted information and education messages that are highly visible and culturally appropriate.

The IAP, through public-private partnership, represents an unprecedented opportunity to achieve the goal of 90% age-appropriate vaccination by 2 years of age – truly not "business as usual."

The IAP, consisting of 39 program objectives, with 30 Lead and Collaborating Agencies, has been awarded $1.8 million by CDC for 1992-93 and focuses on three areas: service delivery, information and education, and assessment. It calls for the following: adopting the *Standards for Pediatric Immunization Practices* by all public and private vaccine providers; developing linkages between vaccination and public assistance programs such as WIC; expanding vaccination service delivery throughout the state by providing staff for expanded clinic hours and locations; taking steps to maximize reimbursement for vaccine and vaccination services; providing a variety of culturally sensitive and targeted information and educational materials; launching a statewide media campaign; and developing methods of measuring coverage among specific groups.

The IAP, through public-private partnership, represents an unprecedented opportunity to achieve the goal of 90% age-appropriate vaccination by 2 years of age – truly not "business as usual." As a carefully planned and managed initiative, it can result in achieving the nation's and Indiana's objective by the year 2000.[3]

The *Standards for Pediatric Immunization Practices*

A cornerstone of the IAP is to optimize vaccine delivery statewide in both the public and private sectors. This includes avoiding missed vaccination opportunities, using simultaneous vaccination, removing barriers to immunization and educating parents and providers.

To address such issues, the National Vaccine Advisory Com-

mittee (NVAC) and a 35-member working group drawn from 24 different public and private sector professional organizations and numerous state and local health departments, including the American Medical Association, the American Academy of Pediatrics, the American Academy of Family Physicians and CDC, developed the *Standards for Pediatric Immunization Practices*. This was done in response to NVAC's recommendation that a formal set of immunization practice standards be adopted by all providers to assure timely vaccination of children since the recent U.S. measles epidemic was caused by failure to vaccinate, not vaccine failure.[1]

The *Standards* call for practices that help eliminate missed opportunities. Other topics addressed include the following: appropriate indications and contraindications to vaccination; audits, tracking, record-keeping and vaccine management; adverse events; use of medical protocols in vaccine delivery; approaches to providing services that incorporate patient- and community-based input; use of properly trained individuals in providing vaccination; and the need for ongoing education and training of providers on current immunization recommendations. Also included is a table specifying valid contraindications to vaccination to help ensure children receive immunizations appropriately *(Table 2)*.

The U.S. Public Health Service approved and the American Academy of Pediatrics endorsed the *Standards* in May 1992. The *Standards* are recommended for use by all health professionals providing care in private or public health care settings who are involved in giving vaccines or managing immunization services for children.

As evidenced by the data above, current health practices fail to deliver vaccine on schedule to a large proportion of the preschool-aged population, due in significant part to missed vaccination opportunities and barriers that impede vaccine delivery. Changes in policies and practices can begin to improve vaccination coverage immediately. The *Standards* represent the most desirable immunization practices that health care providers should strive to achieve and can serve as guidelines to help delineate ways in which immunization polices and practices can be enhanced and modified. While some will take time to be fully implemented, all health care providers are encouraged to use the *Standards* to guide their immunization services.

The ISDH is taking steps to ensure that all vaccination services delivered under its auspices are provided in accordance with the *Standards*. In October 1992, the Indiana State Medical Association House of Delegates adopted Resolution 92-24, endorsing the *Standards* and agreeing to support their dissemination and adoption by members and collaborate in assessing their implementation.

Work is underway with the Indiana Chapter of the American Academy of Pediatrics, the Indiana Association of Public Health Physicians and Indiana Academy of Family Physicians to obtain their endorsements as well. Widespread recognition of these fundamental standards in childhood vaccine delivery will go a long way toward enhancing the vaccination status of Indiana's children. ❑

To obtain a copy of the Standards for Pediatric Immunization Practices, *write to the Indiana State Department of Health, Immunization Program, Acute Disease Division, 1330 W. Michigan St., Indianapolis, IN 46206.*

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References

1. The National Vaccine Advisory Committee: The measles epidemic: The problems, barriers and recommendations. *JAMA*, 266:1547-1552, 1991.

2. Curtis R: *Policy Bulletin: Report on the Employers-Sponsored Health Benefit Plans Survey*. Health Insurance Association of America, Washington, DC, October 1991.

3. Public Health Service. Healthy People 2000: National Health Promotion and Disease Prevention Objectives – Full Report with Commentary. Washington, DC: U.S. Dept. of Health & Human Services, Public Health Service, 1991; DHHS Publication No. (PHS) 91-50212.

Commission criticizes fee-for-service system

Jean Terry
ISMA Legislative Assistant

The Indiana State Health Policy Commission's final report openly condemns the present fee-for-service system and suggests that the system leads to overutilization of services and even unnecessary care.

The commission's final recommendations were delivered to Gov. Evan Bayh in mid-November. The report represents the culmination of three years of work by the members of the commission. Their 700-page proposal, called HoosierHealth – A Strategic Plan for Indiana's Future, is comprehensive in nature and has an impact on all aspects of the present health care delivery system.

The commission's report focuses on managed care and suggests that some of the unnecessary care may actually be harming patients.

An article in the September/October 1992 issue of INDIANA MEDICINE highlighted the portions of the commission's report that had been released at that time. Since then, new chapters and ideas have been added. This article summarizes the first chapters and explains the chapters released since the last article was published.

The commission's report focuses on managed care and suggests that some of the unnecessary care may actually be harming patients. Therefore, under its managed care system, the commission recommends that providers be paid on either a capitated or a salaried basis.

The managed care system would revolve around primary health care. Primary health care providers – physicians, hospitals and ancillary health care providers – could establish primary health care teams. The primary health care physician who is a member of the team would manage the care given by the team. The organizing provider could include any number or type of providers on the team, which would be paid a global or capitated fee for services provided.

If a patient needs the services of a specialist, defined as any provider who is not part of the primary health care team, the managing primary health care physician would have to refer the patient to the specialist. Under this plan, patients would no longer be allowed to self-refer to a specialist. An exception is made for patients who would be willing to pay a higher co-payment or deductible. The primary care physician would maintain control of the referred patient's health care by monitoring treatment and outcomes, unless an agreement between the physician and the specialist stated otherwise.

Managed care is especially prescribed for the critically, catastrophically and chronically ill of the state. The commission has estimated that 3% of the population under the age of 65 uses up to 37% of the state's total health care budget. Because this small percentage of the population is using such a significant amount of the state's health care, the commission recommends that these patients be removed from the present system and placed in a more carefully managed system called a "system of excellence."

The commission also proposed that the present licensing system be reformed and that the state develop its own practice guidelines.

Since the last INDIANA MEDICINE article, many new ideas have been added to the commission's report. A chapter discussing the uninsured population in Indiana was completed, and the data were released and analyzed. According to the report, only 12% of the individuals in the state are uninsured on a long-term basis. Of that number, 15% "could clearly afford" to purchase health coverage but choose not to. Another 15% are poor or near-poor and cannot afford insurance. The remaining percentage could afford insurance if it were more moderately priced.

For the poor or near-poor, the commission recommends introduction of a Medicaid "medically needy" program, an option for states under the federal Medicaid law. The purpose of the program

is to serve low-income people who need medical services but who do not qualify under the state's regular Medicaid program, referred to as the categorically needy program. Under the medically needy program, people with incomes above the Medicaid eligibility level may reduce income to the necessary level by spending income on health care, called "spending down." About 30 states already have established medically needy programs.

The commission believes that adding this Medicaid option will have a significant impact on Indiana's health care system. First, it would provide health care to people who now do not have access to care. Second, the medically needy program would reduce cost shift now experienced when uninsured poor people use emergency and other catastrophic health services. Finally, the state would be able to receive new federal dollars that can be used to treat the uninsured.

No new state funds would be needed to fund the medically needy program. Funding would come partially from money now being used to fund the Hospital Care for the Indigent (HCI). The rest of the savings would come from limiting benefit coverage under the present categorically needy Medicaid program. The commission recommends that the following services be limited under Medicaid: non-emergency transportation, primary care office visits, chest x-rays, emergency room visits without a subsequent hospital admission, chiropractic visits, outpatient psychiatric services rendered by mental health providers, podiatric services and pharmacy services for over-the-counter analgesics and antipyretics. The money saved from limiting these Medicaid services and from eliminating the HCI program, together with the federal match dollars, would fund the new medically needy program.

Additionally the commission recommends that Medicaid follow the managed care system outlined in its report and use a preferred provider network. Only providers selected by Medicaid would be able to serve the Medicaid population.

The commission's final recommendation on Medicaid is that its present reimbursement strategies be re-evaluated. It suggests that physicians use a fee schedule that can be "defined through a scale of relative values." A conversion factor that converts relative value units to dollar values, including multipliers to adjust for geographic location, is included in the reimbursement proposal.

Earlier, a study of provider taxes was included in the report. However, this recommendation was removed before the proposal went to a final vote.

The commission also proposes reforms for the insurance industry. One recommendation is that Indiana adopt a minimum loss ratio policy. Under this policy, an insurance company offering health benefits would have to guarantee that a certain percentage of premiums would be paid out in benefits. The report argues that this type of policy would force third-party payers to become more efficient by giving the insurers an incentive to decrease their administrative expenses.

The report does not include recommendations about any of the following insurance reforms: ending the use of pre-existing clauses, guaranteeing portability and insurability or moving toward a community rating system. Generally, these types of insurance reforms are found in other health reform proposals.

The commission also discusses the need for the government to become a more responsible payer. Because the government is the largest purchaser of health care, the commission reports that its continued financial irresponsibility will increase the current cost-shift phenomena among providers.

Only two commission members voted against the report, Rep. Charlie Brown, chairman of the House Public Health Committee, and Jerry Payne, one of the two labor representatives. Brown and Payne support a single-payer universal health system.

If the governor accepts this plan as recommended, legislation could be introduced during the 1993 Indiana General Assembly. According to a master implementation schedule included in the report, if enabling legislation is passed this session, implementation on almost all parts of the plan is scheduled to begin by July 1993.

The ISMA Department of Government Relations will continue to monitor the progress of this report. Physicians are encouraged to contact the governor and their legislators and express their views on the final recommendation. ❑

Health care tops legislative agenda

Mike Abrams
ISMA Director of Government Relations

Legislators returned to the Indiana Statehouse in Indianapolis this month to begin what is certain to be a legislative session mired in controversy. Budgetmakers will find themselves in the unenviable position of saying "no" at a time when pressing needs in education, health care, including mental health, and environmental problems are pleading for more resources.

Political dynamics, which have been at least minimally predictable in past sessions, are new because 21 members of the 100-member House of Representatives have never served in the House before, and seven senators have never served in the 50-member Senate before.

Perhaps more than in any legislative session in recent history, health care issues will occupy the attention of Indiana legislators. Health care is sure to occupy much of the legislators' time because of recent developments, including reform efforts in other states, the release of the report of the Indiana State Health Policy Commission and increasing fiscal pressure on Indiana's Medicaid budget.

Reform efforts in other states

Several states have refused to wait for the federal government to tackle health care reform and have implemented bold initiatives on their own. The efforts of these states and the publicity generated by their efforts help bring health care reform to the top of the legislative agendas in legislatures across the country.

One of the most notable reform efforts occurred in Minnesota, where many of that state's uninsured will be covered by a new system called MinnesotaCare. By July 1994, people with incomes as high as 225% of the federal poverty level will be covered by this state-subsidized system.

Perhaps more than in any legislative session in recent history, health care issues will occupy the attention of Indiana legislators.

Funding for the program has been the most controversial element of MinnesotaCare. The program will be funded by a 5-cent cigarette tax increase, bringing Minnesota's tax to 48 cents per pack, compared to Indiana's 15.5 cents per pack tax. Further funding will be generated by a 2% gross receipts tax on health care providers. Quarterly, physicians practicing in Minnesota will be required to remit 2% of their gross office earnings to the government to help fund MinnesotaCare.

Several other states, including Vermont, Florida and Colorado, have enacted major health reform initiatives.

Indiana State Health Policy Commission

After working for three years, the state health policy commission released its final report and recommendations to the legislature in November.

The report recommends the formation of a series of competing health care teams, made up of various health care providers, including medical specialists and ancillary providers. Patients would access the system through the team with which they have contracted to manage their care. Each patient's care and access to providers within the team would be managed by the team's primary care physician, which each team would be required to have.

The more than 600-page report recommends many changes, among them: expanded scope of practice for physician assistants and nurse practitioners; "systems of excellence" (hospitals and other facilities that specialize in treatment for certain diagnoses) for critical care patients; and a clinical panel system, governed by a board of directors made up of a majority of non-clinical consumers, to recommend and disseminate practice parameters.

The report is critical of fee-for-service medicine, indicating that "practitioners receive higher levels of income by providing additional care, even though a portion of these extra services offer little additional benefit."

Indiana Medicaid

Indiana's Medicaid system offers 28 of the 31 optional health services that the federal government allows states to offer, such as chiropractic. This generous benefits package, coupled with the extremely strict eligibility requirements, causes Indiana's Medicaid system to spend more per capita on Medicaid recipients than most other state Medicaid programs.

The Medicaid fiscal dilemma is real. Between 1989 and 1993, state funding for Medicaid increased at the rate of 15% per year. The only other general fund category that grew at a rate of more than 6% per year was corrections, which grew at a rate of 14% per year. The current state budget spends 20% on Medicaid, while the state budget of 1985 spent only 10% on Medicaid.

Fiscal leaders are wrestling with methods that could be used to tame the "Medicaid monster."

Likely 1993 health issues

Given that health reform will be an issue during this legislative session, Hoosier physicians entered the debate with adoption of the Health Access Indiana resolution at the 1992 annual Indiana State Medical Association meeting in October. This resolution calls for introduction of a multi-faceted bill aimed at making insurance more affordable and, therefore, more accessible. Among the provisions of Health Access Indiana:

- Insurance reform that would prohibit pre-existing condition clauses and waiting periods.
- Implementation of a primary care case management program for Medicaid. The State Health Policy Commission reported that more than $150 million could be saved in Indiana's Medicaid budget if a "gatekeeper" program could be implemented. Similar programs have been implemented in Wayne County (Detroit), Michigan, and statewide in Kentucky and a number of other states.
- Increased spending on graduate medical education and on programs to encourage physicians to practice in rural areas.
- An increase in the state's alcohol and tobacco taxes to fund rural health programs and graduate medical education.
- A mandatory motorcycle helmet law with no age restriction, recognizing that more than 60% of the costs associated with treating motorcycle injuries come from public programs such as Medicaid.
- Medicaid "anti-hassle" legislation that would try to recapture some of the physicians who are limiting the number of Medicaid patients they see because of unnecessarily burdensome regulations.

The 1993 legislative session will also see efforts by Indiana's trial lawyers to make changes in the Indiana Compensation Act for Patients. Although they were unable to get an interim study committee to recommend an increase in the maximum allowable damage award in a medical liability case, trial lawyers have indicated that they will seek legislation to increase the cap, currently set at $750,000, beyond $1 million.

Other issues that ISMA will work on this year include:

- **Mass screening test results:** Sen. Greg Server (R-Evansville) has agreed to introduce legislation that would require the Indiana State Department of Health to promulgate regulations that require groups doing mass health screenings to counsel those participating in the screen about appropriate follow-up.
- **Corporal punishment:** Sen. John Sinks (R-Fort Wayne) will introduce a bill on behalf of the ISMA that seeks to prohibit corporal punishment in Indiana schools and day care centers.
- **AIDS testing:** Legislation will be introduced on behalf of the ISMA that would require hospitals to offer to test patients for HIV. This bill would not have an impact on the current requirements for

Fewer lawyers serve as legislators

There will now be only 10 attorneys in the Senate (20%) and 15 attorneys in the House (15%). By contrast, 32% of the members of the Senate from 1923 to 1963 were attorneys, and 22% of the House were attorneys during that same period.

Across the country, according to a September 1992 article in the *National Law Journal*, fewer lawyers are serving as legislators, making the lawyer/legislator "a dying breed." ❑

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documented consent.

- **Triplicate prescriptions:** A legislative attempt will be made to repeal the triplicate prescription program.
- **Immunization:** Rep. William Crawford (D-Indianapolis) will introduce legislation to allow private physicians to immunize Medicaid patients with vaccine provided to them at no charge by the state department of health.
- **Drunk driving:** Sen. Tom Wyss (R-Fort Wayne) will introduce legislation to reduce from .10% to .08% the percentage of alcohol by weight in a person's blood that is necessary to constitute prima facie evidence of driving while intoxicated.

During the last long session, in 1991, legislators introduced 1,698 separate bills. Early indications are that at least that number will be introduced during this session.

No amount of grassroots legislative activity is too much. The topics that legislators will be debating will have a profound impact on how patients receive health care in Indiana, and physicians must be an involved voice if legislators are to be expected to vote responsibly in the area of health care.

The Indiana State Medical Association provides several ways for physicians to be involved in shaping legislative issues:

* **ISMA legislative newsletter:** The newsletter is mailed from Indianapolis every Friday and provides a quick look at the week's activities in the Statehouse. Sign up to get the newsletter and, most importantly, react to the information in the newsletter.
* **ISMA Medicine Day at the Statehouse:** Plan to be in Indianapolis on Jan. 27. A breakfast briefing will be held for physicians at the Hyatt Regency. Physicians will then be taken to the Statehouse to lobby their legislators on issues important to Indiana health care.
* **ISMA Legislative Hotline:** During the state legislative session, the Legislative Hotline (1-800-358-ISMA) is updated daily. The hotline includes information that you need to know to call legislators and affect their votes on important issues. ❑



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Why physicians should be involved in the political process

Sen. Pat Miller
R-Indianapolis

Whether you like it or not, changes – big changes – are looming on the horizon for health care. As a physician, you have a unique opportunity to help shape the agenda.

A survey conducted in September by *The Indianapolis Star* reported that more than half of Indiana's voters favored some form of national health insurance. These numbers, which came from a statewide *Star* survey, are consistent with other polls conducted throughout the country.

The fact is that health care reform – a phrase that carries different meanings for different groups and individuals – is one of the most talked-about issues in society today.

According to the pollster in charge of the *Star* survey, the widespread support for national health care doesn't mean that people have made up their minds on how the program should be funded or administered.

"There's a lot less concern among the American public about how you do it, than that you do it," the pollster told the *Star*.

Any type of health care reform will ultimately be decided by your elected representatives in the Statehouse, the White House, the legislature and Congress.

While Congress debates national health care, legislation addressing medical malpractice, insurance coverage, cost containment, third-party reimbursement, licensure and scope of practice will likely be discussed during the 1993 state legislature, as well as in years to come.

Practitioners and patients alike will be affected by these decisions. The involvement of Indiana's physicians is essential to ensure that legislative changes to the system do not sacrifice quality and accessible health care.

Of the 877 bills introduced during the 1992 General Assembly, 101 included the word "physician." While many of these measures would not have wrought substantive change to the practice of medicine, legislation is filed every year that, if adopted, could jeopardize the quality of health care in our state.

Measures that address health care are often incredibly complex. When a bill comes up for a vote, legislators need accurate, complete information so they can make informed decisions.

A good network of physician advocates at the grassroots level can play an invaluable role in the eduction process.

Indiana is fortunate to have a part-time citizen legislature. Your state lawmaker may also be a coworker, a neighbor, a fellow Little League parent, a member of your church or even a patient. Grassroots advocacy simply means getting to know your legislators – in much the same way as you get to know others in your community – so they will look to you as a source of information.

Grassroots advocacy also means patient education. It means talking about health care legislation to others in your community so they can work with you on carrying the message to lawmakers.

As I advise every group I address, it only takes a minute to pick up the phone or drop a letter in the mail.

Why should physicians, who certainly have enough to keep them busy, get involved in the legislative process? Because everyone else is getting involved! Hardly a day goes by that lawmakers are not contacted by groups and individuals seeking some type of health care reform.

Often, physicians are silent while others are speaking out.

Physicians are best qualified to address the medical implications that any type of reform will have on their patients. That's why it's vital that you, as a physician, take the time to speak on these issues and make your voice heard.

Chances are good that changes are coming to our system of health care. Unless physicians throughout Indiana take time now to get involved in the political process, chances are even better they're going to be left wondering what happened. ❑

State Sen. Pat Miller is chairman of the Senate Health and Environmental Affairs Committee.

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COLA program meets CLIA requirements

Editor's note: This article was prepared by the Commission on Office Laboratory Accreditation.

Confusion, frustration, uncertainty and sometimes outrage are feelings often expressed by physicians as they prepare to comply with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations. Most physicians are concerned about the additional costs associated with CLIA. The Commission on Office Laboratory Accreditation (COLA) recognizes that physicians are flooded with information and advice about how to comply with the regulations.

Despite this overwhelming information flow, many physicians are unaware of the single most critical option available for complying with the new federal standards - the option of participating in a private nonprofit accreditation program. Physicians have two options for meeting the CLIA certification requirements: 1) full participation in the federal program, including a biennial on-site inspection conducted by trained government inspectors; or 2) obtaining accreditation from a Health Care Financing Administration (HCFA)-approved private, nonprofit, peer-reviewed accreditation program, such as COLA.

COLA wants physicians to have the necessary information to select the most economical and acceptable approach for meeting the CLIA requirements - whether they choose to participate in COLA or in the HCFA program. This question-and-answer article will provide a basic understanding of COLA services and how COLA fees compare with the federal program.

For more information, call the COLA office in Silver Spring, MD, at (301) 588-5882.

What is the COLA program?
COLA is a voluntary nonprofit accreditation and education program for physician office laboratories. COLA is committed to providing physicians and their laboratory staff educational opportunities to assure that testing in their offices is accurate. The COLA program began in 1988 and is sponsored by the American Academy of Family Physicians, the American Medical Association, the American Society of Internal Medicine and the College of American Pathologists. An aggressive campaign by these organizations influenced Congress' decision to include private accreditation as an alternative to federal certification to promote competition, private sector involvement and freedom of choice for physicians.

Will I meet CLIA requirements if my laboratory is accredited by COLA?
Yes. In July 1992, COLA submitted an application to HCFA for review of its standards. HCFA is in the process of reviewing the COLA application and will likely complete the review process in the next several weeks. The director of HCFA's Office of Survey and Certification has stated, "HCFA will not issue a bill for a compliance fee to any laboratory which indicates on their application that they will seek accreditation until the determination on COLA's application has been made." Once approved, COLA will have "deeming authority" from the federal government under CLIA '88 standards. Laboratories that are accredited by COLA are deemed to meet federal CLIA requirements. The laboratory is not only accredited by COLA, it also is certified by HCFA under CLIA '88.

What are my obligations to HCFA if I enroll in COLA?
All laboratories in the country, regardless of whether they are enrolled in a private accreditation program, must register with HCFA by completing the HCFA-109 survey form and paying a registration fee. You already may have completed this process and obtained either a certificate of waiver or a registration certificate for nonwaived testing. Last November, all laboratories should have received a CLIA Application Packet. Physicians enrolled in COLA or planning to enroll in COLA can indicate it on the CLIA Application Form.

The cost of a Certificate of Accreditation, which must be paid to HCFA, is $100 every two years. Laboratories seeking accreditation will be required to share the costs of HCFA's accreditation validation surveys of COLA-accredited laboratories. This fee will range from $42 to $144 every two years.

Those physicians who decide to participate in COLA will not be required to pay HCFA a biennial compliance fee (i.e., the cost of the

federal inspection). Laboratories enrolled in COLA will not participate in the federal biennial on-site inspections process. Rather, COLA-accredited laboratories will be surveyed every two years by trained COLA surveyors.

Does COLA offer proficiency testing?
COLA is not a proficiency testing program. Regardless of whether you decide to participate in COLA or in the federal program, you must purchase a proficiency testing package from an approved proficiency testing program. The cost of your proficiency testing package is not included in the COLA fee or the cost of the federal inspection.

What services does COLA provide?
In addition to fulfilling the federal requirements imposed by CLIA, your participation in COLA will provide these services:

- COLA offers the opportunity to conduct a comprehensive self-survey to help prepare you for the COLA on-site survey. The checklist you use to complete your self-survey is the same as that used by our COLA surveyors during their on-site visit. COLA will evaluate the self-survey and provide a report of deficiencies that can be corrected before your on-site survey;
- Physicians can receive up to 15 hours of Category 2 CME credit for participating in this self-survey process;
- COLA's surveyors are trained to assist laboratory staff and offer suggestions, hints and technical advice to help them improve laboratory performance. COLA surveyors have experience in the physician office laboratory setting.
- COLA's medical technologists are available by phone to offer technical assistance.
- COLA provides information regarding all regulations related to office laboratory testing including Occupational Safety and Health Administration requirements and the Stark Amendments (i.e., self-referral issues), not just CLIA.
- COLA provides concise articles and fact sheets on various technical aspects of the office laboratory practice – articles that are easily understood and provide specific information to solve problems.
- COLA provides technical guides to assist physicians in conducting good laboratory practices and in meeting COLA standards. For example, the *COLA Guide to Quality Assurance* provides information to office lab workers in non-technical language and provides a reference about quality assurance.
- COLA's Board of Directors is comprised of practicing physicians who set policies that are sensitive to the needs

Table

How COLA biennial fees compare to HCFA inspection fee

Two physicians, four specialties, 12,000 tests/year:	
COLA fee	$1,200
Validation fee paid to HCFA	$82
Accreditation fee paid to HCFA	$100
Total fees for COLA lab	$1,382 vs. HCFA inspection fee – $1,645
Three physicians, three specialties, 15,000 tests/year:	
COLA fee	$1,260
Validation fee paid to HCFA	$70
Accreditation fee paid to HCFA	$100
Total fee for COLA lab	$1,430 vs. HCFA inspection fee – $1,400
Four physicians, four specialties, 20,000 tests/year:	
COLA fee	$1,360
Validation fee paid to HCFA	$82
Accreditation fee paid to HCFA	$100
Total fee for COLA lab	$1,542 vs. HCFA inspection fee – $1,645
Eight physicians, four specialties, 60,000 tests/year:	
COLA fee	$1,720
Validation fee paid to HCFA	$107
Accreditation fee paid to HCFA	$100
Total fee for COLA lab	$1,927 vs. HCFA inspection fee – $2,135

of their peers.
- In addition to its sponsors, COLA is endorsed by the American Osteopathic Association, Oklahoma Medical Association, American Association of Clinical Endocrinologists, American College of Rheumatology and the American Academy of Neurology.

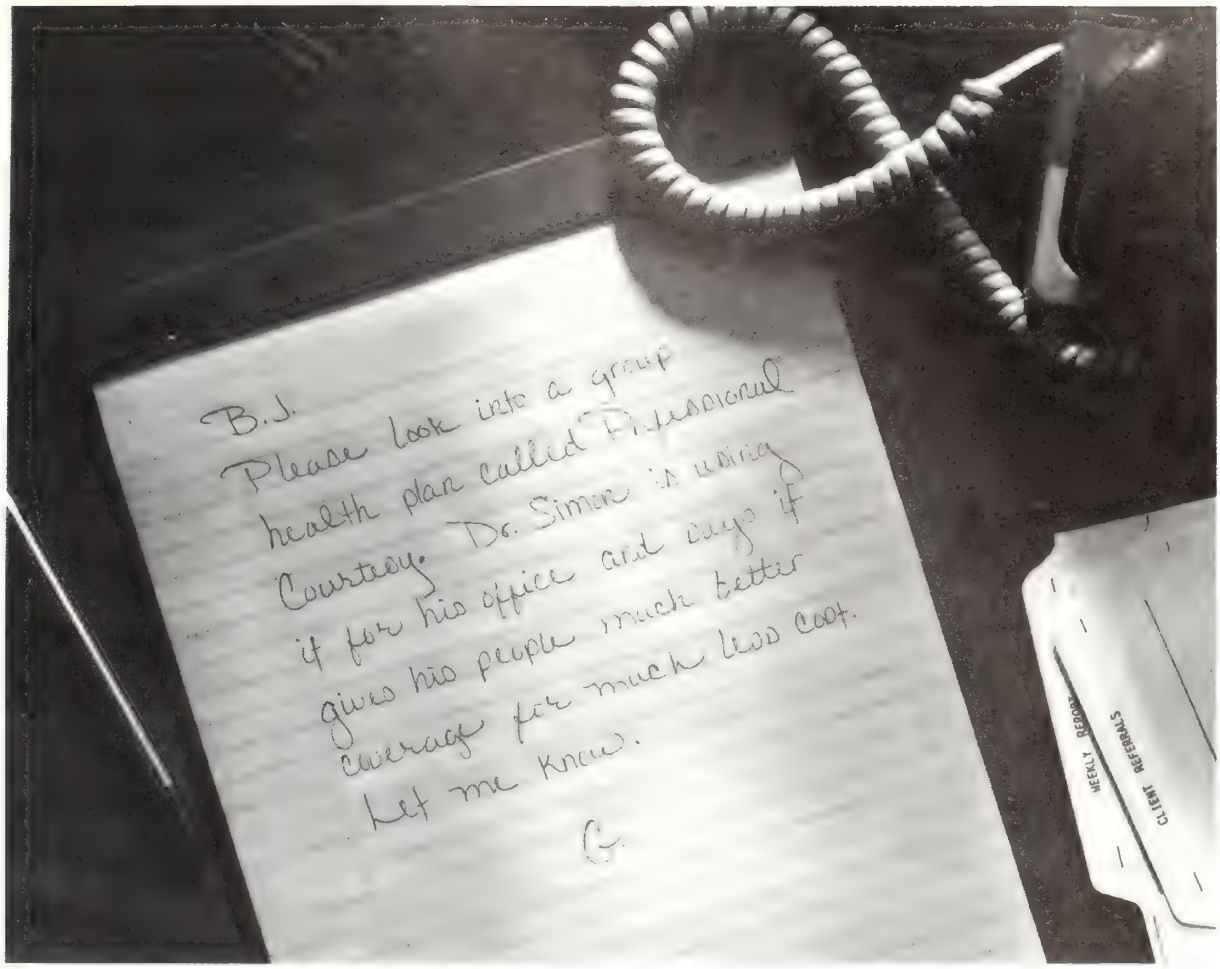
In addition to these services, COLA offers certainty and reliability regarding our standards of accreditation – we will not change our standards from week to week or month to month.

Are COLA fees competitive with HCFA compliance fees?
Yes, and in many cases COLA fees are lower than the HCFA compliance fees. The examples in the *Table* demonstrate how COLA fees compare with HCFA's cost of an inspection. HCFA's biennial cost of an inspection is based on the annual volume of testing and the number of specialties of testing performed. COLA's fees are determined by the number of physicians using the laboratory and the number of specialties of testing performed. Many physicians have had questions about whether the CBC is counted as one test under the federal program. You must count the total number of individual analyses and one for differential for the CBC as a part of your annual volume of testing.

COLA-Accredited Laboratories must pay:
* a one-time federal registration fee ($100 to $350 for most physician office labs);
* a biennial fee to HCFA for a certificate of accreditation ($100);
* a biennial accreditation validation fee to HCFA ($42 to $144); and
* COLA's biennial accreditation fee.

For full participation in the federal program, labs must pay:
* a one-time federal registration fee ($100 to $350 for most physician office labs); and
* the HCFA federal biennial inspection fee ($840 to $2,870).

In circumstances where a COLA surveyor needs to resurvey a laboratory, COLA may charge the laboratory for the cost of the non-scheduled visit (e.g., when there is a complaint that cannot be resolved without an on-site visit). HCFA also will charge the laboratory for the costs of an additional on-site survey resulting from a complaint. In addition to this kind of circumstantial fee, HCFA can impose a monetary sanction on a laboratory for failure to comply with CLIA standards. ❑



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Physicians needed for risk management program

It's not too late for Indiana primary care physicians to register for a pilot project in risk management education.

Called Practice Assessment/Quality Improvement (PA/QI), the project began in May 1992 in Indiana, one of eight states chosen as a pilot site. The Indiana State Medical Association is sponsoring Indiana's participation, with assistance from the Physicians Insurance Company of Indiana (PICI). PA/QI was developed by the Oregon Medical Association in collaboration with the Patient Safety/Risk Management Subcommittee of the AMA/Specialty Society Medical Liability Project.

Here are some commonly asked questions and answers about the project:

Q. What are the components of the program?

A. The three components are: 1) a self-assessment survey that inventories non-clinical risk management behaviors; 2) a home study course describing five hypothetical primary care physicians and details of actual medical malpractice claims; and 3) an on-site office survey by a risk management expert.

Q. What are the benefits of the PA/QI project?

A. The main benefits are:

- the opportunity to have your office practice fully assessed from a patient safety/risk management perspective and to see how you compare to your colleagues nationwide;
- the opportunity to earn six category 1 credits toward the AMA Physician Recognition Award for participating in parts 1 and 2 of PA/QI and to earn six prescribed hours of American Academy of Family Physicians credit; and
- the opportunity to improve the quality of patient care, minimize patient injury and reduce the risk of malpractice litigation if you correct any deficiencies uncovered during the assessment.

Also, because PICI believes PA/QI is so valuable, it is offering a 5% premium discount to PICI insureds.

Q. Why should I use this approach to risk management?

A. There are at least three important reasons.

First, because PA/QI, particularly parts 2 and 3, is specialty specific, it may be easier than with traditional lectures and seminars in risk management for you to identify and implement desirable changes in your practice.

Second, PA/QI was developed by physicians, for physicians. It is based on the notion that fault-finding and punishment impede quality improvement. Rather, PA/QI offers physicians the chance to compare their performance to the performances of their peers. It is an opportunity for reflection, study and for the exercise of a judgment that changes are or are not desirable under the circumstances.

Third, because PA/QI is data-based, it can measure if efforts to change risk management practices in your medical office bring about a reduction in your exposure to future malpractice claims.

In addition, although PICI employees are coordinating the program and conducting the on-site visitations, the results of your PA/QI efforts will not be shared with company underwriters or otherwise used in an adverse manner. All information you provide is completely confidential.

Q. How much of my time is involved in the project?

A. The self-assessment survey will take about 45 minutes to complete, and the home study course will require about four to five hours. The on-site survey takes about four hours total, which includes about one hour of the physician's time during an individual meeting with the surveyor and 15 to 30 minutes at the end of the visit during the summary conference. The rest of the site survey time is spent with other selected key staff members, such as the office manager, the physician's nurse or medical assistant and the receptionist.

Q. If I decide to register for PA/QI, do I have to participate in all three components?

A. No, you can complete only parts 1 and 2 if you choose.

Q. What will this cost me?

A. The charge is a total of $125 for parts 1 and 2 and $100 for part 3. However, as mentioned above, you can elect to sign up for parts 1 and 2 only.

Q. Is there a discount if more than one physician in an office participates?

A. Yes, there is a reduced rate for part 3, the on-site survey, if more than one physician in an

office participates and if the survey for all the physicians is conducted at the same time.

Q. What is the registration fee used for?

A. It covers the cost of supplies from the AMA and travel expenses for the office surveyors.

Q. Do I have to be insured through PICI to participate?

A. No. All Indiana primary care physicians, including family physicians, internists and pediatricians, are eligible. You do not have to be insured through PICI and you do not have to be a member of the ISMA to participate.

Q. How can I enroll?

A. To participate or obtain more information, call Barbara Killila, PA/QI project coordinator, (317) 469-4100 or 1-800-284-7424. ❑

Survey assesses office practices

Here are some sample questions from the PA/QI self-assessment survey:

- I monitor my appointment schedule to ensure that patients wait less than 30 minutes.
- I, or someone else in my office, discuss fees and other charges with patients.
- I have a follow-up system for a patient who is referred for diagnostic testing.
- My staff has been instructed not to renew prescriptions without my approval.
- I return patient calls in a timely manner.
- New patients fill out a questionnaire on their current complaints and previous history.
- I review and initial all incoming medical lab reports before they are placed in the chart.
- My office has a system for verifying that a patient was seen by the consulting physician.
- I document the patient's informed refusal to undergo a recommended treatment or procedure.
- When I make a correction in the chart, I do not erase the error, but draw a line through it, add the correction, date and sign it. ❑

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If you're searching for Charles R. Thomas, M.D., look for the man wearing the tie with the grape motif. It's his way of "subliminal advertising."

Dr. Thomas is the founder and owner of Chateau Thomas Winery in Indianapolis and a southside Indianapolis obstetrician and gynecologist.

Twenty years ago he was making wine in his basement, pressing his eight children into helping him. Today, he turns out internationally award-winning wines in downtown Indianapolis and counts some of the world's most famous vintners as friends.

Before Dr. Thomas started making wine, he was not even a regular wine drinker. However, he says, "I was always impressed with the elegance and flair that wine gives to a meal."

His wine-making venture began unexpectedly one night in 1970. He stopped in a wine-making supply store when he had some time to spare after bowling and walked out with enough materials to set up a home winery.

Eventually he grew disenchanted with the concentrates he was using and started investigating ways to improve his product. In search of advice, he traveled to California wineries and enrolled in a wine appreciation class at Indiana University-Purdue University at Indianapolis. Through Marcia Mondavi, daughter of vintner Robert Mondavi, he met a California grape grower who could sell him Cabernet grapes. He flew home from his 1978 trip to California with 25 gallons of Cabernet grapes.

His results with the Cabernet grapes were so successful that he duplicated the process in 1979 and 1980. In 1981, however, he was ready for further refinements in his wine-making.

When he couldn't bring fresh grapes back to Indiana any more because of the Mediterranean fruit fly infestation, "Marcia (Mondavi) came to my rescue," he said. She knew someone in Berkley, Calif., who bought grapes from growers, then had them crushed, blast-frozen and held in cold storage until needed. This process, Dr. Thomas explained, allowed the grapes to be trucked anywhere and used when convenient.

The frozen-grape method paid off for Dr. Thomas. He was able to make several kinds of wine and in larger quantities and won several gold medals in regional competitions. Merlot, Chardonnay and Cabernet Sauvignon were among wines he made from frozen grapes.

Dr. Thomas soon was ready to uncork a new idea. "Wineries in Indiana don't get any respect," he told his wife, Jill. "I'm going to see if I can change that."

His wife was not surprised by his plan. "What took you so long?" she asked him.

And so, in January 1984 he opened a winery in an office/warehouse complex south of Beech Grove. Two years later the winery moved to another building on the southside of Indianapolis, where it remained for two years before relocating to its present location at 501 S. Madison Ave.

Since 1986, Chateau Thomas has made its wine from fresh grapes instead of frozen. The varieties of wines available include Chenin Blanc, Cabernet Sauvignon, Sauvignon Blanc, Merlot, Chardonnay, Zinfandel, Fleur d'Peche, Pinot Noir, Foch and Late Harvest Zinfandel, a red house wine and a white house wine.

Many wines have won awards, including the International Eastern Wine Competition, the San Diego National Wine Competition, *The Dallas Morning News* International Competition, the "Wines and Spirits" International Wine Competition and the

Charles R. Thomas, M.D.

I like being a physician because: I appreciate my independence, although it is slipping fast. I enjoy the daily challenges medicine brings; you don't get bored. I enjoy meeting people, helping people and problem solving.

If I weren't a physician, I would be: Either a teacher or a scientist, such as a chemist.

I relieve stress by: For some reason, I rarely feel stress. I am pretty even-tempered. I enjoy classical music and "new age" music, but I don't have to have it to relax. ❑



Dr. Thomas offers tours, wine tastings, educational seminars and a gift shop at his Chateau Thomas Winery.

Indiana State Fair.

Dr. Thomas never stops learning about or sharing his knowledge of wines. Since 1975 he has been the senior instructor on wine appreciation at IUPUI. He has written several articles on wine and health and related subjects. He is an avid reader of wine journals and books and belongs to such wine-related groups as the Confrerie de la Chaine des Rotisseurs, L'Ordre Mondial des Gourmets Degustateurs, the International Wine and Food Society, Les Amis du Vin, the Indianapolis Wine Society and the Bacchus Society. He holds the second highest rank in the Confrerie des Chevaliers du Tastevin and is the maitre d'cave of the Indianapolis unit of the Confrerie des Compagnons Gouste Vin de Normandie, an organization exclusively for physicians and one of only three chapters outside of France. As the maitre d'cave, he is responsible for selecting wines for the group's dinners and talking about them during the meal.

To learn about wine making from some of the world's best vintners, he has traveled to some French wineries. He's still learning the French language though. "I can read wine bottles and get to the bathroom," he jokes.

Son Steve is now the winemaker, but "we still do most things together," Dr. Thomas said. Despite a daily schedule of delivering babies and performing surgery, Dr. Thomas helps oversee the operation of the winery.

Dr. Thomas firmly believes in the health benefits of moderate consumption of wine. He cites studies that show heart attack rates are lowest in such countries as France, Germany, Italy and Spain, where drinking wine during long, leisurely meals is the custom.

He is disturbed by the stance of the Bureau of Alcohol, Tobacco and Firearms on wine. The BATF is listening to "neo-prohibitionists" who want more regulations and warnings on the dangers of alcohol, he says, and ignoring its own committees espousing the health benefits of wine.

A drinker of wine in moderation for 15 years, Dr. Thomas is proof that wine can play a part in a healthy lifestyle. "My own cholesterol profile is excellent," he says. "I attribute that at least in part to the wine." He also stays healthy by using a treadmill and a stationary bicycle while watching medical videos.

Although he doesn't encourage people to consume alcoholic beverages, he does tell people that if they choose to drink, wine is the best choice – in moderation and with meals. ❑



Dr. Thomas is proud of his 1988 Merlot, which won a gold medal in international competition.

Thrombolysis in acute myocardial infarction:

A hospital emergency room experience

Roland B. McGrath, M.D.
Indianapolis

Abstract

Thrombolysis has become a well-established alternative in the management of acute myocardial infarction. The timing of the initiation of thrombolytic agents is important in determining outcomes. There has been great interest in understanding the delays from onset of symptoms to the initiation of thrombolysis. The experience at Wishard Memorial Hospital in Indianapolis was monitored and reviewed for comparison to other metropolitan area experiences.

The value of thrombolysis as an alternative in the early management of selected patients with acute myocardial infarction (AMI) is established. The relative importance of time from onset of chest pain to delivery of the thrombolytic agent has been emphasized. Dissection of the components of delays has received some attention,[1,2] and there have been attempts to understand, even attenuate, these delays.[3-16] In this context, the practice at Wishard Memorial Hospital in Indianapolis was reviewed for comparison to descriptions of other metropolitan area experiences.

Methods

The Wishard Memorial Hospital emergency department is Indiana's busiest, with more than 100,000 patient visits in 1991. The hospital is the base for the city's emergency prehospital transport service.

Thrombolysis candidacy guidelines are detailed in *Table 1*.

Patients with chest pain are evaluated by Indiana University internal medicine residents (PGY 2 or 3) and/or faculty. The decision to initiate a thrombolytic ordinarily includes consultation with, but not necessarily the presence of, the assigned cardiology fellow and/or faculty.

All three commonly used thrombolytic agents are available in the emergency department, and the choice of agent rests with the cardiology fellow and other treating physicians. The doses used are standard (30 units of Eminase over 3 to 5 minutes, 1.5 million units of Streptase over 60 minutes, 10 mg bolus followed by consecutive infusions of 50 mg over 60 minutes, then 40 mg over 120 minutes of Activase).

The records of all emergency department patients receiving a thrombolytic for AMI Jan. 1 through Dec. 31, 1991, were reviewed. In addition to patient name, age, sex, hospital record number and date, the mode of transportation was recorded. The times of onset of pain, ambulance dispatch, ambulance arrival at the scene, initiation of transport and emergency department arrival were identified. The electrocardiographic location of AMI, the time of initiation and the choice of thrombolytic agent were noted. Intervals from onset of pain, dispatch, scene, transport, emergency department arrival and initiation of thrombolytic were calculated.

Results

There were 26 patients identified. The mean age was 58 (range 34 to 74); there were 18 men and eight women. Twenty patients were transported by the Wishard Ambulance Service, two by other prehospital providers and two by private automobile. The transportation of two others could not be determined.

The time of day was scattered with 11 patients appearing between midnight and 8 a.m., five

from 8 a.m. to 4 p.m., and 10 from 4 p.m. to midnight.

The time from onset of pain to the initiation of the thrombolytic could be determined accurately in only 22 of the 26 patients. The mean was three hours, 29 minutes, with a range of one hour, 35 minutes, to six hours, 35 minutes. Prehospital times could be stratified in the following manner: symptoms to call for assistance, 92 minutes (18 patients); response or dispatch to scene, 5.8 minutes (20 patients); scene, 17.2 minutes (20); and transport, 9.4 minutes (20). The mean time from emergency department arrival to initiation of the thrombolytic agent was 69 minutes, with a range of 25 minutes to three hours and 57 minutes. Sixteen (62%) had the thrombolytic initiated in ≤ 60 minutes of emergency department arrival.

There were 17 inferior and nine anterior AMIs by the initial electrocardiogram (ECG).

Of the patients on whom a thrombolytic was initiated, one patient's (Streptase) infusion was discontinued before completion because of hypotension, and one patient received the full dose of thrombolytic but retrospectively had only myocardial ischemia and a ventricular aneurysm.

Table 1

Criteria for the use of thrombolytic agents in acute myocardial infarction

Thrombolytic therapy is indicated for patients with the following:
- Cardiac chest pain unrelieved by SL NTG.
- Duration of chest pain > 30 minutes but ≤ six hours.
- ≥ 1 mm ST elevation in at least two contiguous leads.

Contraindications:

Absolute
1. History of stroke, AV malformation, brain tumor.
2. Recent surgery or major trauma (≤ 10 days).
3. SBP < 80 mm Hg unresponsive to fluid or atropine infusion.
4. Active internal bleeding or bleeding diathesis.
5. Aortic dissection
6. Known allergy to streptokinase or recent streptococcal infection (for APSAC and streptokinase only).

Relative
1. Age ≥ 75 years.
2. Renal insufficiency (creatinine > 2.5).
3. Severe hypertension (SBP ≥ 180, DBP ≥ 120) refractory to immediate therapy.
4. Acute pericarditis.
5. Left bundle branch block or high-degree AV block on ECG.
6. CPR ≥ 10 minutes.
7. Hemorrhagic diabetic retinopathy.
8. Recent history of GU bleeding.
9. Patient receiving warfarin.
10. Strongly heme positive stool.

Discussion

The importance of early thrombolysis in AMI has overwhelming support in the literature. Some have attempted to understand the delays in the various components of time from onset of symptoms to the initiation of thrombolytics. Sharkey detailed delays from symptom onset to thrombolytic administration and revealed that more than half of the total time occurred in the emergency department.[1] Gonzalez[2] reviewed 210 cases treated in 13 hospitals in Virginia. Emergency department delays could be categorized as ECG time (11 minutes), decision time (31 minutes) and process time (23 minutes); these represented almost 40% of delays from onset of symptoms to thrombolytic administration. Time advantages were associated with urban locations, teaching hospitals, increasing volume of AMI, thrombolytic stocked in the emergency department, initiation of thrombolysis in the emergency department and permitting emergency physicians to make treatment decisions. An additional correlate was the use of Eminase. In the Wishard experience, about 60% of the total time (onset of chest pain to initiation of the thrombolytic) was prehospital.

Delays before arriving in the emergency department have been associated with means of transport. Hartman[17] describes a delay of 198 minutes from pain onset to the initiation of thrombolytic for patients providing their own transportation, compared to 100 minutes for those using ALS prehospital providers.

Kereiakes[7] reviewed pub-

lished experiences of paramedic chest pain evaluation in eight communities. There could be 3,868 patients identified cumulatively, with a mean response time of 7.7 minutes (study means range from 4.0 to 8.2), scene time 25.8 minutes (16.3-28.0) and transport time of 12.6 minutes (7.1-24.5). Scene time was prolonged because of prehospital ECG protocols. The one series identifying a control group revealed a mean scene time of 16.1 minutes.[8]

Delays from the time of emergency department admissions to initiation of the thrombolytic agent have been documented in multiple major metropolitan areas *(Table 2)*. The experience recorded from the Wishard emergency department (69 minutes) is easily compatible with reported practices (range 55 to 103 minutes).

Three major interventions have been explored with the intent to decrease delays from symptom onset to the initiation of thrombolytics.

Ho[3] attempted to manipulate the behavior of prospective patients with an educational program involving the media (two newspapers, seven radio stations and three television networks). The intervention cost $139,000 and was acknowledged by the community but did not significantly alter delay or use of the emergency medical service system.

Using both historical and/or concurrent controls, prehospital electrocardiography is associated with decreased symptom and emergency department admission to initiation of thrombolytic times.[6-8] Prehospital electrocardiograms have been technically transmitted to emergency departments with a 90% success rate but may prolong scene time to more than five minutes.[4-8]

Finally, prehospital administration of thrombolytic agents has been investigated. Eight series[9-16] with 316 patients have been reported since 1985. All agents, including urokinase, have been used. These studies have been conducted in Europe, the Middle East, USSR and Australia but not in the United States. There is confirmed benefit to time from onset of pain to the initiation of the thrombolytic agent and probable benefit to limit size of infarction, improve left ventricular function (clinical congestive heart failure, end diastolic pressure, and ejection fraction) but no benefit to mortality.

This article details the experience of the use of thrombolytic agents in AMI at the Wishard Memorial Hospital. Patient candidacy criteria, patient subsets and delays in initiating the agents are provided. The available reported experiences of other metropolitan areas are reviewed in order to put the Wishard experience into appropriate context. ❑

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References

1. Sharkey SW, Brunette DD, Ruiz E, et al: An analysis of time delays preceding thrombolysis for acute myocardial infarction. *JAMA*, 262:3171-3174, 1989.

2. Gonzales ER, Ornoto JP, Jones LA, et al: Prospective multicenter assessment of critical factors delaying hospital thrombolytic therapy. *J Am Coll Cardiol*, 17:247A, 1991.

3. Ho MT, Eisenberg MS, Litwin PE, Shaeffer SM, Damon SK: Delay between the onset of chest pain and seeking medical care: The effect of public education. *Ann Emerg Med*, 18:727-731, 1989.

4. Grim P, Feldman T, Martin M, Donovan R, Nevins V, Childers RW: Cellular telephone transmission of 12-lead electrocardiograms from ambulance to hospital. *Am J Cardiol*, 60:715-720, 1987.

5. Aufderheide TP, Henoley GE,

Table 2

Time from onset of symptoms to initiation of thrombolytic agents

City		Minutes
Salt Lake City	1990	103 (68*)
Minneapolis	1989	90
Cincinnati +	1990	84
Indianapolis	1991	69
Richmond +	1991	64
Chicago +	1986	55

* interventional group
\+ other communities in addition

Thakur RK, et al: The diagnostic impact of prehospital 12-lead electrocardiography. *Ann Emerg Med*, 9:1280-1287, 1990.

6. Weaver WD, Eisenberg MS, Martin JS, et al: Myocardial infarction triage and intervention project - Phase II patient characteristics and feasibility of prehospital initiation of thrombolytic therapy. *J Am Col Cardiol*, 15:925-931, 1990.

7. Kereiakes DJ, Weaver D, Anderson JL, et al: Time delays in the diagnosis and teatment of acute myocardial infarction: A tale of eight cities. *Am Heart J*, 120:773-780, 1990.

8. Karagounis L, Ipsen SK, Jessop MR, et al: Impact of field transmitted electrocardiography on time to in-hospital thrombolytic therapy in acute myocardial infarction. *Am J Cardiol*, 66:786-791, 1990.

9. Koren G, Weiss AT, Hasen Y, et al: Prevention of myocardial damage in acute myocardial ischemia by early treatment with intravenous streptokinase. *N Engl J Med*, 313:1384-1389, 1985.

10. Castaigne AD, Duval AM, Dubois-Rande JL, Herve C, Jan F, Lavard Y: Prehospital administration of anisoylated plasminogen streptokinase activator complex in acute myocardial infarction. *Drugs*, 33:231-234, 1987.

11. Villemant D, Barriot P, Riou B, et al: Achievement of thrombolysis at home in cases of acute myocardial infarction. *Lancet*, 1:228-229, 1987.

12. Weiss AT, Fine DG, Applebaum D, et al: Prehospital coronary thrombolysis - A new strategy in acute myocardial infarction. *Chest*, 92:124-128, 1987.

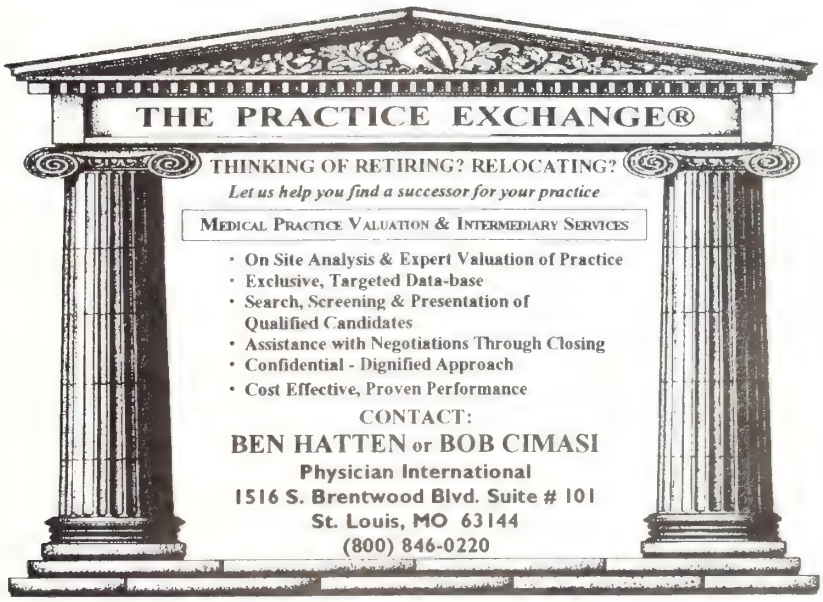
13. Bossaest LL, Demey HE, Colemont LL, et al: Prehospital thrombolytic treatment of acute myocardial infarction with anisoylated plasminogen streptokinase activator complex. *Crit Care Med*, 16:823-830, 1988.

14. Roth A, Borbash GI, Hod H, et al: Should thrombolytic therapy be administered in the mobile intensive care unit in patients with evolving myocardial infarction? A pilot study. *J Am Coll Cardiol*, 15:932-936, 1990.

15. O'Roorke, Gallagher D, Healy J, et al: Paramedic-initiated prehospital thrombolysis using urokinase in acute coronary occlusion. *J Am Coll Cardiol*, 17:246A, 1991.

16. Varshavsky SY: Prehospital thrombolysis in acute myocardial infarction. *Prehospital Disaster Med*, 7:57-59, 1992.

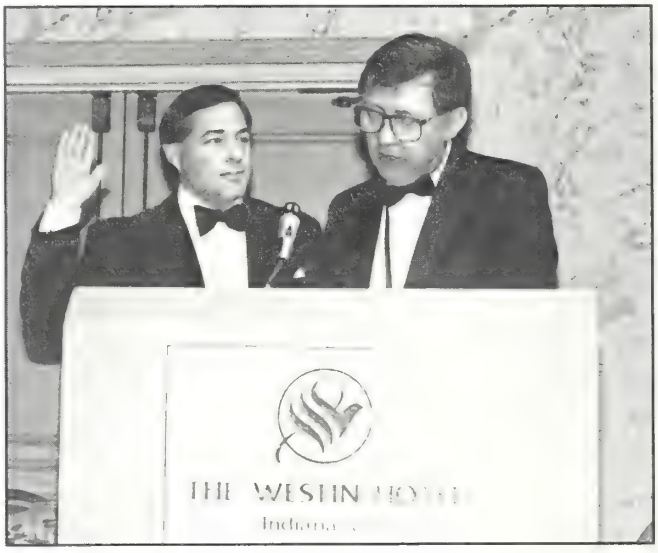
17. Hartmann JR, McKeever LM, Bufalino VB, Amipraviz F, Seanlin PV: Intravenous streptokinase in acute myocardial infarction: Experience of community hospitals served by paramedics. *Am Heart J*, 111:1030-1034, 1986.



1992 ISMA convention highlights



William H. Beeson, M.D., ISMA president, enjoys President's Night with his wife, Pam.



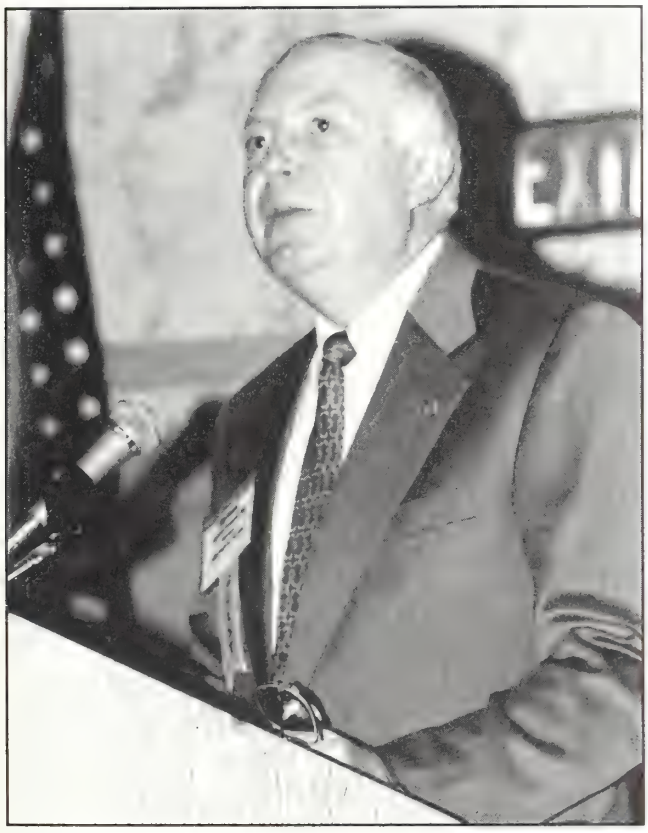
William H. Beeson, M.D., an Indianapolis facial plastic and reconstructive surgeon, is sworn in as president by outgoing ISMA president, C. Dyke Egnatz, M.D., a Schererville family physician.



Cal Thomas, a conservative syndicated newspaper columnist, is surrounded by autograph seekers following his speech at the convention's annual IMPAC luncheon.



Robert Morgan, a student at the Indiana University School of Medicine, is the first place winner in the scientific exhibit competition.



Raymond Scalettar, M.D., AMA board chair, addresses the opening session of the ISMA House of Delegates.



Lee Smith, M.D., a South Bend ophthalmologist, left, talks with Richard Walker, M.D., of Clear Lake, Tex. Dr. Walker, an obstetrician/gynecologist, presented the risk management seminar.



Awaiting the opening session of the House of Delegates are, from left, Paul Forman, a medical student; Fred Haggerty, M.D., a Greencastle family physician; and John Thomas, M.D., a Fort Wayne otolaryngologist.



Robert A. Ward, M.D. of Perry County listens to proceedings at the opening session of the House of Delegates.



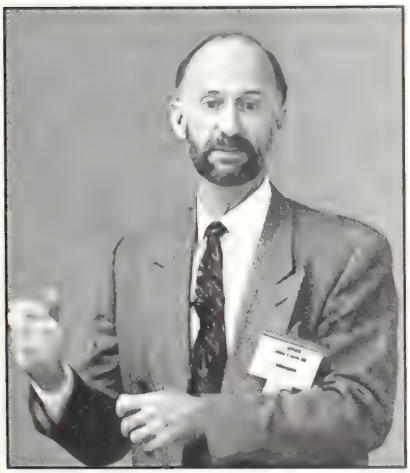
Regino Urgena, M.D., a Marion anesthesiologist, left, talks with Eusebio Kho, M.D., a Scottsburg surgeon.



Steven Elliott, M.D., an Evansville family physician, is the winner of the 1992 Physician Community Service Award. Dr. Elliott was recognized for his efforts as an advocate for the medically underinsured and uninsured and for helping found the Washington Avenue Health Care Center in Evansville. Dr. Elliott is medical director of the center, which serves the indigent.



Alvin Haley, M.D., an Indianapolis family physician, speaks at the meeting of Reference Committee 3.



James R. Davis, M.D., an Indianapolis psychiatrist, speaks at the spouse program sponsored by the ISMA Auxiliary. The program topic was "The American Family in Crisis: Some Solutions for the '90s."



Stephen Tharp, M.D., a Frankfort internist, left, discusses the products at the Indiana Bell Ameritech exhibit with Ameritech representatives Fred Kaiser and Marti Risley.



Panelists at the program on "Alzheimer's Disease...From Research to Caregiving are, from left, Geneva Shedd, Indiana Division on Aging and Rehabilitative Services; Hugh C. Hendrie, M.B., Ch.B., Department of Psychiatry, Indiana University School of Medicine; Fay Ebrite, Area IV Agency on Aging and Community Services; and Willard Mays, Indiana Division of Mental Health.

1992 ISMA convention coverage

Call to order, miscellaneous business

The Indiana State Medical Association House of Delgates convened its 143rd Annual Convention at 9 a.m., EST, Friday, Oct. 16, 1992, at the Westin Hotel in Indianapolis. The final session of the House of Delegates convened at 9 a.m., EST, Sunday, Oct. 18, 1992.

Presiding at both sessions was William Van Ness II, M.D., speaker, Summittville, assisted by William E. Cooper, M.D., vice speaker, Columbus. Larry, Allen, M.D., Anderson, served as parliamentarian. Paul Riley, M.D., Indianapolis, presented the invocation.

Approval of minutes

The proceedings of the 142nd Annual Meeting of the House of Delegates, Indiana State Medical Association, conducted Nov. 8-10, 1991, at the Westin Hotel, Indianapolis, and published in the January/February issue of INDIANA MEDICINE, were approved.

Addresses/reports

The addresses of the president, president-elect and president of the ISMA Auxiliary (all referred to Reference Committee 1) were filed with commendation.

All reports (printed in the September/October 1992 issue of INDIANA MEDICINE) and additional supplemental reports were filed, with the exception of the treasurer's report, which is referred for audit.

Election of officers

William H. Beeson, M.D., Indianapolis, president-elect, succeeded to the office of the president. William Van Ness II, M.D., Summittville, was elected president-elect. Other elections included:

Treasurer – John Bizal, M.D., Evansville

Assistant treasurer – Timothy Brown, M.D., Crawfordsville

Speaker of the House – William Cooper, M.D., Columbus

Vice speaker of the House – Peter Winters, M.D., Indianapolis

Chairman, Board of Trustees – Jerome Melchior, M.D., Vincennes

Clerk/chairman pro tem, Board of Trustees – Frank Sturdevant, M.D., Valparaiso

At-large member, Executive Committee – Alfred Cox, M.D., South Bend

At-large member, Executive Committee – John Thomas, M.D., Fort Wayne

Election of delegates, alternate delegates to the AMA

The following were elected to two-year terms as delegates and alternate delegates to the American Medical Association (terms expire Dec. 31, 1994).

Delegates:

Shirley Khalouf, M.D., Marion

John Knote, M.D., Lafayette

George Lukemeyer, M.D., Indianapolis

Alternates:

Alfred Cox, M.D., South Bend

C. Dyke Egnatz, M.D., Schererville

Max Hoffman, M.D., Covington

Holdover AMA delegates and alternate delegates (terms expire Dec. 31, 1993) are:

Delegates:

Edward Langston, M.D., Indianapolis

John MacDougall, M.D., Beech Grove

Marvin Priddy, M.D., Fort Wayne

Alternates:

Michael Mellinger, M.D., LaGrange

George Rawls, M.D., Indianapolis

John Thomas, M.D., Fort Wayne

Trustees/alternates, 1992-1993

The House of Delegates confirmed the newly elected/re-elected trustees and alternates, 1992-1993.

Trustees:

District 1 – Bruce Romick, M.D., Evansville

District 2 – Jerome Melchior, M.D., Vincennes

District 3 – Gordon Gutmann, M.D., Jeffersonville

District 4 – Art Jay, M.D., Lawrenceburg

District 5 – Fred Haggerty, M.D., Greencastle

District 6 – Ray Haas, M.D., Greenfield

District 7 – Ron Blankenbaker, M.D., Indianapolis

District 7 – John Records, M.D., Franklin

District 7 – Bernard Emkes, M.D., Indianapolis

District 8 – John Osborne, M.D., Muncie

District 9 – Stephen Tharp, M.D., Frankfort
District 10 – Frank Sturdevant, M.D., Valparaiso
District 11 – Jack Higgins, M.D., Kokomo
District 12 - John Thomas, M.D., Fort Wayne
District 13 – Alfred Cox, M.D., South Bend
RMS – Clint Myers, M.D., Indianapolis
MSS – Paul Forman, Indianapolis

Alternate trustees:
District 1 – Barney Maynard, M.D., Evansville
District 2 – James Beck, M.D., Washington
District 3 – John Seward, M.D., Bedford
District 4 – Lawrence Bailey, M.D., Aurora
District 5 – Roland Kohr, M.D., Terre Haute
District 6 – Howard Deitsch, M.D., Richmond
District 7 – Frank Johnson, M.D., Indianapolis
District 7 – Paula Hall, M.D., Mooresville
District 7 – Ron Stegemoller, M.D., Danville
District 8 – Susan Pyle, M.D., Union City
District 9 – Daniel Berner, M.D., Lafayette
District 10 – Thomas Brubaker, M.D., Munster
District 11 – Larry Musselman, M.D., Marion
District 12 – Joseph Mantheiy, M.D., Bluffton
District 13 – Richard Houck, M.D., Michigan City
RMS – Carla Brumbaugh, M.D., Carmel
MSS – Scott Hollingsworth, Indianapolis

Future meetings

1993	Oct. 15-17	Westin
1994	Oct. 21-23	Westin
1995	Oct. 20-22	Westin ❑

In memoriam

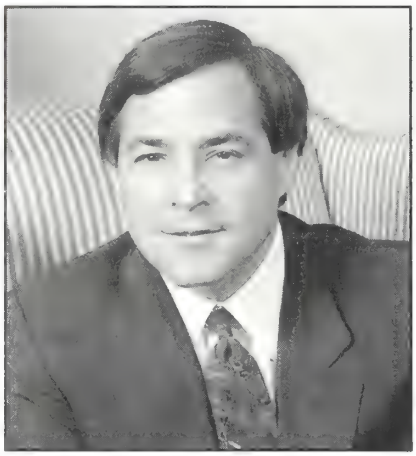
The ISMA pays tribute to its members who have died since the 1991 session.

Adriano A. Agana, M.D., Gary
William M. Anshutz, M.D., Indianapolis
Amos Arney, M.D., Michigan City
James L. Arrowsmith, M.D., Munster
Clarence C. Atkins, M.D., Rushville
Earl W. Bailey, M.D., Carmel
Frank A. Benchik, M.D., East Chicago
Rudolf L. Boha, M.D., Floyds Knobs
Howard B. Brenner, M.D., Munster
Howard E. Burg, M.D., Evansville
Robert J. Byrne, M.D., Bicknell
Robert E. Chattin, M.D., Loogootee
Robert G. Cook, M.D., Bluffton
Edward R. Cotter, M.D., Hammond
Alfred J. Dainko, M.D., Whiting
Delfin P. David, M.D., Kokomo
Vladimir Dvorak, M.D., Frankfort, Ky.
Ralph W. Elston, M.D., Fort Wayne
Marvin A. Evens, M.D., Indianapolis
Howard M. Faust, M.D., Anderson
Isadore E. Friedman, M.D., Munster
Erling S. Fugelso, M.D., Bloomington
William J. Gerding, M.D., Fort Wayne
Kenneth L. Glasser, M.D., Indianapolis
Milton H. Gustafson, M.D., Muncie
Robert A. Hedgcock, M.D., Frankfort
Paul G. Iske, M.D., Indianapolis
Francis P. Jones, M.D., Indianapolis
Satish C. Julius, M.D., Boonville
John T. Kemp, M.D., Michigan City
William F. Kerrigan, M.D., Connersville
Kenneth W. Koss, M.D., Muncie
Joseph L. Larmore, M.D., Carmel
Homer L. Life, M.D., Muncie
Robert P. Lloyd, M.D., New Smyrna Beach, Fla.
Frederick A. Loop, M.D., West Lafayette
Glenn C. Lord, M.D., Indianapolis
Shobhana D. Mehta, M.D., Terre Haute
James R. Mensch, M.D., Fort Wayne
Orval J. Miller, M.D., Fort Wayne
Richard H. Miller, M.D., Fort Wayne
Roland E. Miller, M.D., West Lafayette
Georgia B. Mitchell, M.D., Gary
Herschel C. Moss, M.D., Indianapolis
Samuel A. Motanya, M.D., Fort Wayne
Lillian G. Moulton, M.D., Terre Haute
Josephine F. Murphy, M.D., Niles, Mich.
Earl J. O'Brian, M.D., Indianapolis
Tracy C. Owens, M.D., Indianapolis
Constantine G. Panos, M.D., Bluffton
Jashbhai N. Patel, M.D., Fort Wayne
John D. Pattison Jr., M.D., Marion
James P. Powell, M.D., Sun City, Ariz.
Richard C. Powell, M.D., Indianapolis
Harold E. Rendel, M.D., Peru
Norman F. Richard, M.D., Shelbyville
H. Jerome Rietman, M.D., Evansville
Ronald D. Roberts, M.D., Columbus
Warren C. Roberts, M.D., Indianapolis
Hubert J. Ryan, M.D., New Smyrna Beach, Fla.
Malcolm O. Scamahorn, M.D., Pittsboro
Herbert A. Schiller, M.D., South Bend
John C. Shattuck, M.D., Brazil
William B. Smith, M.D., Indianapolis
Robert M. Stoltz, M.D., Valparaiso
David B. Templin, M.D., Crown Point
Morris E. Thomas, M.D., New Smyrna Beach, Fla.
Jack M. Troy, M.D., Hammond
Gary C. Williams, M.D., Indianapolis
William L. Wissman, M.D., Naples, Fla.
Ladislas D. Wojcik, M.D., Marion
Jonathon G. Yoder, M.D., Goshen
John M. Young, M.D., Indianapolis ❑

William H. Beeson, M.D., installed as president of the ISMA

William H. Beeson, M.D., an Indianapolis facial plastic surgeon, took office as president of the Indiana State Medical Association Oct. 17 at the annual ISMA meeting in Indianapolis.

Dr. Beeson, a 1976 graduate of the Indiana University School of Medicine, has served the ISMA as speaker and vice speaker and as a member of the Commission on Medical Affairs and the Commission on Sports Medicine. He is secretary of the American Academy of Facial Plastic and Reconstructive Surgery, treasurer of the American Academy of Cosmetic Surgery and a board member of the Accreditation Association for Ambulatory Health Care. He is a past president and past chairman of the board of the Marion County Medical Society.



Dr. Beeson

He serves as a site surveyor for the Accreditation Association of Ambulatory Health Care and is a member of the Society of Ambulatory Surgeons and the Federated Ambulatory Surgery Association.

Dr. Beeson is certified by the American Board of Otolaryngology, the American Board of Cosmetic Surgery and the American Board of Facial Plastic and Reconstructive Surgery. He has written many journal articles and textbook chapters on facial plastic surgery and is the senior author and editor of two textbooks.

His community activities include serving as chairman of the physician section of the United Way Campaign for Central Indiana and as a member of the Indiana Chamber of Commerce Health Care Committee and the board of the Marion County Chapter of the American Cancer Society and the executive committee of the Indiana University Alumni Association. ❑

William VanNess II, M.D., chosen ISMA president-elect

William C. VanNess II, M.D., a Summitville family physician, was chosen president-elect of the Indiana State Medical Association during the annual meeting.

A 1972 graduate of the Indiana University School of Medicine, Dr. VanNess has held several positions with the ISMA, including speaker of the house, Eighth District trustee, chairman of the board, alternate delegate to the American Medical Association and chairman of the future planning committee.

He has served as president of the Madison County Medical Society and president of the Anderson Community Hospital medical staff. He is a member of the board of directors of Madison County HealthSearch.

Dr. VanNess is certified by the American Board of Family Practice. ❑



Dr. VanNess

Address of the president, C. Dyke Egnatz, M.D.

I'm not sure who really pays attention to reports such as this. Officially, this report will be filed.

It's also not my style to entrap your attention with a litany of all the wonderful things that happened this past year.

That almost reminds me of the story about the billboard artist that stepped back off the scaffold in order to admire his work.

Rather, I wish to review the concepts that I perceived in accepting the responsibility to serve as our president, not your president.

As a solo family practitioner, my formal time participation in organized medicine at the ISMA goes back to 1968, when I was an alternate delegate from Lake County. That time and effort may well parallel the efforts of those of you who tithe to their church.

As time went on, my participation evolved with a two-fold intent. First, I believed in a personal responsibility as a member of our profession to maintain awareness of our role in society and second, to tithe to our medical congregation and help maintain the position of medicine within our society.

Needless to say, once the opportunistic entrepreneurs from outside of medicine recognized the fertile economic field to be served or exploited under the name of social service, our force and impact has been gradually outnumbered by public attitude, media sensationalism, government and business capital power interests.

Being a good guy might have worked if everyone within our profession functioned as a good guy. Sad to say, the unethical self-serving individuals who entered medicine for not the best reasons have also diluted our strength and the integrity of our social commitment.

Under these multi-faceted internal and external forces, our professional industry is regressing into a system of feudalism with local and global turf battles for survival and identity.

My objective for this past year has been to direct activities of our organization in areas to strengthen the personal position of every physician in Indiana.

In exchange for that strength in numbers and common goals for public good, I hoped to challenge every physician in Indiana to do his part in practicing medicine:

1. compassion for the impact of illness on the lives of your patients;
2. education of your patients through wellness and preventive measures; and
3. prudent utilization of medical services and technology with cost-effective decisions that involve your patient's input.

Last year, my Resolution 91-29 was to request your participation in organized medicine by being supportive of your elected leadership - at all levels within your practice environment.

Everyone meets their quota of general staff, department and committee meetings because your bylaws state that it is a requirement of reappointment. Not the most ideal intention, but pragmatically effective. If we participated because we honestly cared, the impact on quality care and audience appreciation would go without saying.

To maintain our image and fulfill our commitment, you must show equal support for your leadership by attending county meetings, district meetings and even ISMA and AMA events. If they have been boring, then you must make something happen.

Of the 126 hospitals in Indiana, we average only 10 representatives to the AMA Hospital Medical Staff Convention. This significant resource to your local medical staff is lost to your indifference and apathetic lack of participation.

Reread that resolution and evaluate your own level of participation.

If my platform had two planks, physician satisfaction and physician security are hallmarks to your successful career in medicine.

In helping you attain your personal goals, the ISMA has focused its efforts on educational resources for you and your practice.

The new power is information and knowledge, not money or warclubs. Your ISMA has been working for you on all fronts - legislative information, regulatory information, liability information, business information and patient information.

Learn about those services and utilize them within your practice.

So, what's happened this year?

In reimbursement, the RBRVS

band aid has been continually reanalyzed and updated to maintain your compliance and understanding. Have you and your staff attended the ISMA coding seminars?

In professional liability, our three-year amnesty between ourselves, the trial lawyers and the Indiana Hospital Association formally ends in December. Our retitling of our law as INCAP, the Indiana Compensation Act for Patients, has been promoted and explained to radio, television and newspaper entities throughout the state by our INCAP commando group. This is our social contribution to support control of health care costs escalated by wasteful and frivolous liability claim expenses and payouts.

In legislation, ISMA staff has been super-diligent in maintaining contact and sharing educational information with government leadership. Our Key Contact Program is you. Participate in IMPAC and let your patients and congressmen know your views and concerns.

In Medicare-Medicaid, our liaison committees are continuing to share information and collaborate with consumer and provider representatives.

In health access, we have reviewed and monitored all available information from the governor's Health Policy Commission and are anxiously awaiting the final report, which is due Nov. 1.

In medical education, I served on the dean's committee to evaluate the efficacy of the regional medical school campuses and other proposals to improve primary care.

In rural health, we are participating in studying projects of the Indiana State Department of Health and the IU School of Medicine regarding rural health centers and training opportunities with primary care career exposure for medical students and residents.

Before this extends to a laundry list that I promised not to do, I would like to pause and thank everyone on behalf of Bonnie and myself in making this a rewarding and memorable year.

Thank you's often leave key components out. If I leave you out, you know you were there when it counted.

Rick King and the entire ISMA staff helps make this all happen.

The ISMA Alliance, our support group, is greatly escalating their participation in organized medicine.

Additionally, our experience in visiting our neighboring states was very expansive and informative. Several of those officers are in our audience today.

Thank you to my fellow officers, the board of trustees and you, the delegates, who together are key elements in maintaining our passing parade.

Before closing, it would seem timely to review the health care programs being touted by our presidential candidates and their political parties.

It's a sophisticated form of nichemanship with everyone trying to appeal to the most niches with the most votes.

Correlating that short-term goal of procrastination until after the election with the scare tactics of the media and its fragmented information services is like getting on a merry-go-round or following daytime soaps; it doesn't matter where or when you enter the discussion, you're still at the same place.

There are some health care costs that benefit the entire nation.

If health care is over 10% of the GNP, does health care create over 10% of the jobs? Where will they go in a layoff?

Do health care related companies represent 10% of the business on Wall Street? Will the market hold up without that health care income?

If we are seeking to control costs, why are there no RBRVS controls for medical suppliers and the technology industries?

When will the patient receive an a la carte menu to select medical services for which he agrees to pay?

When will the insurance industry critically review hospital and provider charges as they relate to reimbursement allowances?

Health care is an integral part of the daily life of the entire nation. The goal of quality should be the goal of everyone whose revenue is derived from health care services. Instead, bottom line, stockholder demands and personal gains have taken the front seat, with air bags of special interest legislation for protection.

To pay off the national debt would require a donation of over $47,000 per family in America - credit cards not accepted. With our present rate of deficit, that number is projected to be $300,000 by the next century. So, the health care faction also needs money to be solvent.

Let's focus on the sources of payment or funding for any of the benefit plans:

Social Security – That tax has been collected from citizens who

report their income. Health care expenses, as Medicare, would be expected to be a large component of our retirees requirement.

Employer payroll taxes – It's tough to mandate benefit or cost increases if the profit margins are slim or deficit.

Employee benefit taxation – Probably the most equitable, but our work force does not feel secure enough to be charitable to their uninsured neighbor.

Government insurance pools – If the insurance administrator is not motivated to control payouts, the universal benefit plans will be token, inferior and not enough.

Managed care discounts – If you're never sick, it's like winning the lottery. At what point will consumers be willing to personally pay for the extras – high-tech or priority service? Only when they can't get what they want at someone else's expense. The word "TIP" is the acronym for "to insure promptness." In some societies, doctors are tipped for extra services. Do we want a black market for health care?

Private insurance – This industry can only balance out if health insurance benefits become indemnified and the premiums become more actuarially sound. I remember the days when patients paid for three insurance policies in order to get full coverage reimbursement.

If there were solid indemnity allowances, patients would begin to negotiate for non-covered services. Fair competition may then lower costs. Our current system of managed care, co-payments and deductibles are consumer negotiations without the consumer.

From this explosive fanfare of the components of the health care crisis, if I may borrow a media word, I shall attempt to summarize for a focused message and challenge for the future of medicine.

First, we must conduct ourselves in the image of our profession. Practice with responsible good intentions. It is a lot harder for outside sources to discredit an honest, well-educated and dedicated practitioner or the organization that represents him or her.

Second, you need to vote in the coming elections. You need to stimulate your patients to vote. You must demonstrate to your government officials that you are watching and analyzing their representative efforts and you will stimulate your patients to vote according to your appraisal of their performance. The 1975 passage of our professional liability law is a clear demonstration of what a sincere concentrated effort can do.

Third, we need genuine camaradarie among ourselves. However, in order to command the respect and trust of our colleagues and peers, we must practice in a respectful and trustworthy manner. Remember, the warrior is impeccable. Your position is secure because of what you know. Your position is satisfying by knowing that you are doing it right and for the right reasons.

Some of you in this room may recall the days of newsreels at the movie theaters in the 1940s and 1950s.

One commentator I remember is John Nesbitt with the Passing Parade, an editorial observation of our society.

I feel that I have been privileged to be the 142nd grand marshall of our passing parade.

But, for a passing parade to be effective, it takes more than a grand marshall. Each of you here, and the physicians you represent, must join in the march to make the heritage of our passing parade effective.

Our incoming leadership has taken the baton. The 143rd lap of our relay carries on.

Thank you. ❑

Address of the president-elect, William H. Beeson, M.D.

Mr. Speaker, officers, trustees and delegates, guests:

It has been said that, "of those to whom much is given, much is required." As physicians, we are given privilege and rank that very few others receive. With the privilege comes a tremendous responsibility for the health and welfare of the people we serve. We are indeed fortunate to be living in a country with the best health care system in the world.

Just this past summer, national headlines were made when a 12-year old Iowa farmer's son had his arm severed by a piece of machinery. The headline was not about the farming accident itself. It made news because doctors were able to reattach that boy's arm, and he is fully functional again. Ten years ago, this would not have been possible.

Right here in Indiana similar medical miracles occur. We performed the first newborn twin-to-twin heart transplant in the world. The recipient celebrated her second birthday this past April.

We have accomplished much in the past few years. But one's past record is never something to stand on. It is something to build upon. It is our responsibility as partners in this system to preserve its quality, assure access to every American and make it cost efficient.

As physicians, we need to be actively involved in the health care debate for three reasons:

First we view the health of the public as a major responsibility of the medical profession.

Second, we want to be sure that nobody, not government, not employers, not insurers, use the cost crisis to try to make us the agents for rationing care. It is bad medicine to base patient care recommendations on financial considerations, rather than medical ones, and it is against our code of ethics.

Third, as doctors we know from first-hand experience that the lack of access to care can lead to serious, even fatal, medical consequences.

There are many critical issues and challenges facing us as we move toward the millennium, in the year 2000: out-of-control Medicaid; the professional liability crisis; lack of preventive health care; the ever increasing myriad of governmental regulations; the copious bureaucratic paperwork; and, of course, escalating health care costs which have culminated in a public outcry for health system reform.

I intend to create special task forces to work with our board of trustees and various commissions to meet those challenges head on, to tackle the tough issues and arrive at workable solutions. It is important for organized medicine to take a lead in dealing with the following major issues.

Health system reform

In the United States, $1 out of every $7 paid out by state government goes to pay for Medicaid. That's about 14% in most states. In Indiana, Medicaid costs increased 25% from fiscal year 1991 to 1992 and will account for 20% of our state budget. While Indiana ranks 38th in the nation in income per capita, we are eighth in the nation in the liberal distribution of supplemental Medicaid benefits.

To deal with this problem, I intend to appoint Drs. Tim Brown and Steve Tharp as co-chairmen of a special task force to work with your board of trustees and commission on legislation to develop recommendations on restructuring the Medicaid benefits package and to suggest immediate reforms that can be taken to stem the escalating costs of Medicaid, as well as preserve access to quality care and fair and timely compensation for services.

On Nov. 1, the State Health Policy Commission will issue its final report. Following my address, Dr. Mike Mellinger will fill you in on what we expect the report to include. I intend to ask Drs. Mellinger and John Knote to co-chair a task force to work with the AMA and ISMA staffs to thoroughly review the State Health Policy Commission report and make recommendations to your board of trustees and commission on legislation. They will use the AMA's Health Access America as a benchmark. Their final recommendations will be based upon work already completed by your ad hoc committee on medical economics, the AMA Health Reform Strike Force and reform programs supported by other state medical associations.

Last month, the AMA stepped up its efforts to assist states with developing health system reform proposals. Our ISMA staff has been in contact with the AMA in this regard. Through the efforts

of both, we will have qualified experts with national perspectives assisting us as we pursue health reform in Indiana.

Prevention

All the reforms in the world won't fix the health care crisis unless we renew our emphasis on prevention. A considerable portion of health care costs are a result of our abusive lifestyles, and that tendency starts at an early age.

The President's Council on Physical Fitness and Sports reported in its test of children ages 5 through 8, 40% already showed risk of heart disease, while among 400 teenagers tested, only 36% could pass a basic fitness test.

Smoking, alcohol consumption, illicit drugs, poor diet, obesity and sexual promiscuity are all factors that adversely affect our health. It is inexcusable that each year more than 1.1 million girls ages 10 to 19 become pregnant; that each year 2.5 million teenagers contract a sexually transmitted disease and that 50% of our 12- to 17-year-olds try alcohol and more than half a million of them will try cocaine.

The Centers for Disease Control estimates that these unhealthy habits cause 50% to 60% of all disease and disability in the United States. Prevention is the best cost-containment concept we can utilize. To this end, I intend to ask Dr. Bill VanNess to chair a special task force, composed of representatives from each of our state specialty sections and from our ISMA auxiliary, to explore ways to strengthen health and physical education programs for our youth in Indiana. We must support and assist the Indiana departments of health and education in their efforts to bring back truly comprehensive health and physical education. We must give children the foundation that will allow them to grow into mentally and physically healthy, productive adults.

Professional liability

It is lamentable that at a time when a physician is able to do more for his patients than at any other time in the history of medicine, his risk of being sued by that patient has never been greater. In 1974, this House of Delegates passed a resolution to pursue both professional liability reform legislation and formation of a physician professional liability insurance company. Both of those points have come to fruition. The Indiana Compensation Act for Patients, or INCAP, has been a successful statute. It has balanced access to quality care with fair compensation for patients who are injured and at the same time has created a more stable practice environment for doctors.

This summer, a legislative study commission reviewed INCAP and made no recommendations for changes in the statute. I am asking Drs. Mike Mellinger and George Lukemeyer to co-chair a special INCAP Task Force that would work with your board of trustees and commission on legislation during the upcoming legislative session to preserve and defend INCAP.

Professional liability reform will be a critical issue in the upcoming legislative session. It is imperative that every Indiana physician become actively involved in order to prevent a rekindling of the professional liability crisis.

1. Talk to your legislative representatives and educate them on INCAP.
2. Support them at the polls and support them financially.
3. Be prepared to enlist support of your patients regarding INCAP.
4. Participate in the ISMA key contact network.

As you know, Physicians Insurance Company of Indiana is your ISMA company. ISMA involvement in PICI has been valuable to Indiana physicians in three ways:

First, it's brought competition into the professional liability market. Because of this, subrogation clauses have been deleted from policies, occurrence policies still exist in Indiana, medical corporation fees have been eliminated, and the concept of risk management has been introduced into physician practices.

Second, it has provided support that allows us to pursue lobbying efforts such as INCAP.

And third, it allows us to have access to insurance industry data and have a working knowledge of the insurance industry. This has enabled the ISMA to play an active role through PICI in the "indexing" of insurance premiums and to better understand ways of stabilizing the Patient Compensation Fund.

As physicians, we feel that injured patients should be fairly compensated. But, as in other fields, there are many groundless claims filed. Did you know that four out of every five claims is closed without any payment of damages? I'm concerned that even when damages are awarded that less than 50 cents of each dollar goes to the injured party.

The rest goes to attorney fees and court costs. We need to find ways to decrease the frequency and cost of defending frivolous professional liability claims. We also need to strive to improve the quality of care and decrease our exposure risk.

I'm asking Dr. Dyke Egnatz to chair a task force to explore ways our insurance company can better assess the needs of Indiana physicians in these areas. The committee would also assist in suggesting and developing ISMA-PICI programs on a specialty specific basis, which would enable us to curb the rising costs and increasing frequency of defending ourselves against charges of professional liability.

Self-assessment

As we approach the next millennium, it's appropriate for us to take an introspective look at ourselves, our organization, our resources and our prospects for the future. It's essential that we give our members the best value for each dues dollar they pay. It's essential that we assess how we can be sensitive and responsive to our membership and provide the services they desire in the most efficient and cost effective manner possible. I'm asking Dr. Jerry Melchior to serve as chairman of a special task force to provide this introspective analysis and propose recommendations to your board of trustees for the future.

As your incoming president, I am looking forward to working with Medical Auxiliary President Trudy Urgena and President-elect Sue Greenlee. The auxiliary is in the process of their own strategic planning, and we look forward to working closely with them in coming months.

The road we will travel on in the coming weeks and months is rocky. The path we take will not be easy and will require a full commitment from each of us. These are difficult times, but we have great resources and are in an enviable position. Our potential for progress is extraordinary, and the resources and strengths of your state medical association are particularly well positioned to continue to make an important difference in enhancing the quality of medicine and patient care in Indiana and beyond.

To use the words of Franklin D. Roosevelt, "We have a rendezvous with destiny." We stand at the dawn of a new era. Before us is the most important decade in the history of civilization. A period of stunning technological innovation, unprecedented economic opportunity, surprising political reform and great cultural rebirth. It will be a decade like none that has come before, and it will culminate in the millennium, the year 2000.

And when at some future date the high court of history sits in judgment on those of us who are privileged to have become physicians - recording whether in our brief span of service we have fulfilled our responsibilities - our success or failure will be measured by the answer to this question.

Were we truly men and women of courage, judgment, integrity and dedication?

I pledge to do the best I can possibly do as your president, and pray that with God's help, we will be successful in effecting positive change.

All things considered - looking out on this group, knowing the talents, energy, vitality and wisdom you possess - knowing the commitment and talent of our staff - I'm optimistic that when I again stand before you in 12 months and reflect on what has been accomplished, we will have made this nation and our state a better, healthier place in which to live.

Thank you. ❑

Address of the ISMA Auxiliary president, Trudy Urgena

Greetings from the Indiana State Medical Association Auxiliary!

Dear ISMA Officers and Delegates:

Your auxiliary is about to become your alliance!

As your allies, we can be working more proactively with you. Together, we can take the lead in influencing health care delivery. Instead of reacting to the events that affect medicine and our lives, together we can be evaluating the potential changes on the horizon and planning strategies to effectively insure a positive outcome for medicine.

As we move through this decade into the 21st century, our organization is at the brink of change.

Our membership is changing. We're more educated and career- and goal-oriented. We're more professional. We're more informed and knowledgeable, more active in the legislative process. One-third of our potential members are male spouses.

No longer are we just a fund-raising or a self-centered social group, but an organization dedicated to improving the quality of health across the state. Already we are actively identifying the health needs in our communities, and we are influencing health care legislation on the state and national levels.

The image of auxiliary is in transition, and the national auxiliary has already changed its name to Alliance to reflect our changing nature.

To conform to the new national name, the Long-Range Planning Committee has recommended changing our state name to the ISMA Alliance. Delegates to our annual convention in April will vote on the name change, and if the enthusiasm for the name change remains as high as it is today, your auxiliary will become your alliance next April.

The new name will define our new role. We have always been your advocates, in our separate, quiet and unnoticed ways. Today, however, we are prepared to become more visible advocates: as partners working with you to help Indiana residents lead healthier and more productive lives and to make a positive impact on medical and health care legislation.

We can accomplish this best at the grassroots county level, involving all physicians and their auxiliaries/alliances. It is at the local level where patients are cared for and the community's health is improved and where individual physicians can become involved to influence the outcome of health care legislation.

Two programs endorsed by the American Medical Association that utilize the local medical society/auxiliary teamwork are the Mini-Internship Program and the Family Violence Prevention Program.

The Mini-Internship Program is designed to help legislators and community leaders understand the pressures and concerns of physicians. Done at the county level with physician and auxiliary members, the mini-internships offer a firsthand opportunity for people who affect, implement or report on health care policy to experience the daily practice (and frustrations) of medicine.

Benefits of this firsthand experience include informing legislators and community leaders about problems in health care delivery and countering any inaccurate preconceptions they may have regarding health care.

What better way for grassroots physicians to become involved in the legislative decision-making process than to do what they do best: caring for patients? The only difference would be a legislator "intern" shadowing them during a typical day to learn the realities of medical care.

This program has been successful in numerous other states, including Illinois, Ohio and Iowa. Your auxiliary looks forward to working with you and the ISMA leadership to promote and implement the Mini-Internship Program in Indiana. Health care reform is the legislative issue of the '90s, and all grassroots physicians must learn how to effectively participate in the decision-making process to be able to favorably influence the outcome of health care legislation.

As health care reform is the legislative issue of the '90s, violence is the disease of the '90s. It is as complex and life-threatening as any of the killer diseases of the past. As many as one-fourth of all American households are touched by violence each year.

Family violence knows no boundaries. It is a problem shared by the residents of the affluent suburbs, the inner city and small-town America ... by white collar workers and blue

collar workers ... by professionals and laborers ... by the rich and the poor ... by the educated and the uneducated ... by the young and old ... by people of every race and nationality and ethnic origin. The fact that no one is immune is why family violence has reached epidemic proportions in this country.

Dr. John Knote, your distinguished AMA delegate and ISMA past president, has introduced a family violence resolution to this House of Delegates. It asks county medical societies, in partnership with the auxiliary, to address their individual community needs concerning family violence.

People need to know that we in the medical community are taking the lead in addressing family violence because we are concerned, because we care, because we believe we can make a difference. Help us make a difference. Support and endorse the family violence resolution, number 92-20.

Your county auxiliaries can assist you and your local medical societies in implementing the Mini-Internship and the Family Violence Prevention programs, as well as any other programs that benefit your patients and your communities.

Here with me today are county auxiliary presidents: the people whose dedication, hard work and leadership abilities ensure that your communities' health needs are addressed.

Please recognize and honor them with a round of applause.

As your spouses, we know your frustrations in dealing with the increasing myriad of hassles that sap your time and energy away from patient care. When you begin to feel alone and isolated and that no one cares about you, remember us, your partners, and the only organization that totally supports physicians and the medical family.

As your allies and your advocates, we are your greatest asset. We will use our talents, skills and volunteer time working with you to achieve the highest ideals of the medical profession for the benefit of the people of Indiana.

Thank you. ❑

Scientific exhibit winners

First place
"ATP/$MgCl_2$ ameliorates reperfusion injury"

Exhibitor: Robert A. Morgan, Department of Surgery, Indiana University School of Medicine, Indianapolis.

Limb ischemia and associated reperfusion injury are significant causes of limb morbidity. Reducing reperfusion injury would serve to help salvage otherwise unrestorable limb function. The ability of a solution of low vanadium (<1 ppm) adenosine triphosphate and magnesium chloride (ATP/$MgCl_2$) to improve recovery of skeletal muscle function and reduce skeletal muscle necrosis after four hours of complete ischemia was investigated in an autoperfused canine hind limb model.

Study groups included non-ischemic control limbs (n=7), ischemic control limbs (n=7) and ischemic test limbs (n=7). Ischemic test limbs were continously infused intra-arterially with 2000 cc of 2 mM ATP/$MgCl_2$ adjusted to pH 7.4 with sodium bicarbonate over the course of three hours of reperfusion. Control ischemic limbs were continuously infused intra-arterially with normal saline during reperfusion.

Function was evaluated by determining isometric twitch contactile force of paw dorsiflexion by stimulating the peroneal nerve and the anterior tibial muscle sequentially. Necrosis was evaluated by photographic analysis of sectioned anterior tibial muscle stained with nitroblue tetrazolium dye (NBT). The solution of ATP/$MgCl_2$ significantly increased functional recovery ($p<0.05$) and significantly reduced skeletal muscle necrosis ($p<0.05$). Although further study is needed, ATP/$MgCl_2$ may be helpful in the clinical reduction of limb morbidity. ❑

Second place
"Purification of A-1 antigen"

Exhibitor: Robert Woodburn, Northwest Center for Medical Education, Indiana University School of Medicine, Merrillville.

A mAb termed BIKS was prepared from a hybrid cell (273) obtained by fusing a mouse myeloma cell, P3X Ag-8-653, with spleen cells of BALB/c mice immunized with lymphoid tissue homogenates obtained from a strain 2 guinea pig. The antibod-

ies IgG subclass was IgG1 and the light chain is kappa. Western blot analysis of several tissue homogenotes indicated that the antigenic molecule is contained in polypeptides with apparent molecular weights of 116kd and 55kd (A-1).

The antigen was isolated utilizing an immuno-affinity column with BIKS as the antibody. Immunohistochemical studies (ABC method) demonstrate the presence of the antigen in several cell types arising from the three primitive germinal cell layers, including among others, tissue macrophages, pneumocytes type II and Schwann cells.

Experimental axotomy of the sciatic nerve in guinea pig resulted in a significant increase in the expression of the A-1 antigen in the Schwann cells of the distal segment. This suggests that these polypeptides might play a significant role in the process of Wallerian degeneration. o

Third place - tie
"Hyperventilation & intraocular pressure"

Exhibitor: Julianne Stout, Glaucoma Research & Diagnostic Laboratory, Department of Ophthalmology, Indiana University School of Medicine, Bloomington.

Lowering intraocular pressure (IOP) is the predominant approach to treating glaucoma; however, little is known about the physiological mechanisms controlling IOP. Other researchers have shown that perturbations in end-tidal CO_2 in various time scales can affect ocular tension in humans. Thus, we proposed to determine whether long-term mild hyperventilation, with and without CO_2 addition to maintain isocapnia, can induce a decrease in IOP.

We studied nine healthy subjects for one hour under each of the following conditions: control, guided hyperventilation (to a 12.4% reduction in end-tidal CO_2 relative to control) and hyperventilation with CO_2 added to maintain isocapnia. IOP (as measured by Goldmann applanation tonometry) was not significantly altered after five minutes of hyperventilation. However, after 30 minutes of hyperventilation, IOP decreased by 20.9% from a matched control value (14.8 + 0.81 mm Hg to 11.7 + 0.54 mm Hg [$p<0.05$]). The lowered IOP was maintained at 11.2 + 0.66 mm Hg ($p<0.05$) after 55 minutes of hyperventilation. IOP was not significantly affected by hyperventilation when CO_2 addition was used to maintain isocapnia.

These results show that hyperventilation-induced ocular hypotension appears to be linked both to the decrease in end-tidal CO_2 and to the duration of that decrease.

Third place - tie
"Retinal hemodynamics using SLO."

Exhibitor: Steven L. Mansberger, Department of Ophthalmology, Indiana University School of Medicine, Bloomington.

Retinal blood flow circulation in response to varying blood oxygen content may be compromised in several common disease states. Past work that has examined the retinal circulation under varying PO_2 has failed to control PCO_2. These changes in PCO_2 may independently alter retinal flow.

In this study, 12 young, healthy people underwent noninvasive scanning laser ophthalmoscopy (SLO), to quantitatively examine the effects of hyperoxia and hypoxia while isocapnia was maintained. Three conditions were studied: control (breathing room air), hyperoxia (breathing 100% O_2) and hypoxia (adding N_2 to inspired gas until the end-tidal fraction reached 8%). CO_2 was added as needed to maintain isocapnia. During hyperoxia (end-tidal O_2 fraction 96%), retinal arteriovenous passage (AVP) time of fluorescein dye was lengthened 10% compared with control, while induction of hypoxia shortened arteriovenous passage time 15% compared with control. The difference in AVP time between hyperoxia and hypoxia was statistically significant ($p<0.05$).

We conclude that the healthy retina accelerates or slows its bulk flow in approximate proportion to arterial blood O_2 content. ❑

annual reports

EXECUTIVE DIRECTOR
Richard R. King

Each year, the executive director's report covers what has happened over the past 12 months. This year, my report will focus on several aspects of the future of medicine in the next three years. This forward-looking focus is possible because of the House of Delegate's vision and the board of trustee's oversight in directing activities of ISMA to become the indispensable adjunct to the practice of medicine. This goal has been accomplished through the adoption of the ISMA Strategic Plan by the board of trustees.

The strategic plan has permitted the ISMA to adopt a system to manage change as it affects membership. The ISMA board, since the adoption of the strategic plan in 1989, has provided leadership for an integrated organizational management model, which anticipates the changes in the health care delivery. The elected officers' participation in the strategic plan involves the membership with pride of ownership in this process and the ultimate product/service to the physician members.

Over the past three years, the strategic plan has better prepared the board and ISMA membership to anticipate and meet future opportunities for services. For instance, our practice management, risk management and Medicare programs have reached thousands of members. The board remains fully focused on common objectives of membership in that we are striving to preserve the physician members' autonomy to do what is best for the patient. Our representation of membership in the legislative arena has focused on a "grassroots" effort. The goal is to keep members informed on impending issues so that legislators can be contacted in a timely fashion. Associations and membership in ISMA therein is intertwined with the Indiana health care environment. First, a few words about the ISMA membership status.

ISMA membership has been at a relatively constant level during the past three years:

	Active	Dues exempt	Total
1992	6,076	1,293	7,369
1991	6,015	1,223	7,238
1990	6,087	1,117	7,204
1989	6,019	1,088	7,107
1988	6,094	1,012	7,106
1987	5,969	1,014	6,983

Those physicians not joining the medical association are concentrated in the major metropolitan areas. The demographics for 1992 are as follows: non-members - 2,132 (612 of total are residents); and of the 2,132 non members, more than 750 are between 30 and 40 years old.

Non-member totals for larger counties

Marion	748
Lake	104
Vanderburgh	42
Ft. Wayne	68
St. Joseph	99

We are aware of approximately 8,800 physicians and D.O.s who have obtained professional liability coverage by paying into the Patient's Compensation Fund of the Indiana Compensation Act for Patients. Obviously some of those are D.O.s who are eligible for membership in ISMA who chose to forgo the opportunity. However, overall the association has experienced more than a 22% increase from 1987 to 1992 in dues-exempt members while only sustaining a numerical increase from 5,969 in 1987 to 6,076 in 1992, or less than a 2% increase in active membership. We need to analyze this trend and take some corrective action or the association's membership may not represent the overwhelming majority of practicing physicians. A task force of the board and representatives of the counties may be needed to review and make recommendations to the board in the near future.

The State Health Policy Commission Report was discussed in the September/October 1992 issue of *Indiana Medicine*. One thing that is most definite is that change is upon the practicing physician in Indiana. First, the way physicians organize themselves in order to deliver their services to patients is in the process of a major overhaul. The pressures and hassles on the small or solo family or general practitioner are becoming unbearable. The administrative overhead has increased substantially over the past decade with limited opportunity for increasing gross revenues.

Against this backdrop, one can describe numerous possible scenarios for change in the coming years. Needless to say, the status quo is non-existent with the public opinion pressures on the twin issues of affordable health care and universal access to health care. The following are but a few of the possible scenarios for change in the foreseeable future.

1. Competition among physicians will continue to intensify.

Pressure on the traditional fee for service medicine particularly in the larger metropolitan areas will continue. Incremental changes in the payment of physician services will be accomplished over the next several years.

2. The traditional health insurance companies will continue to merge within the industry, which actions will directly affect negotiations with hospitals and physicians.

3. Employers and government will continue to demand evidence that "managed care" is a good value, thereby demanding proof of quality outcomes. The physician will be forced, in order to survive economically, to produce the best outcomes at a reasonable price within the practice parameter.

4. Physicians, allied health care professionals and ancillary personnel will be forced to consolidate to provide access to financial capital, spread the risk of loss and to contract with payors. Many groups of physicians will be forced to merge to maintain a semblance of the market share. These relationships may be collaborative with the local hospital to provide a future for both.

These mergers require the physicians to develop at a minimum a "shared vision" of the future for the delivery of physician services.

Physician groups are inclined to merge if physicians are experiencing practice administration burnout, lack of time and expertise to respond to a rapidly changing marketplace, the perception of economies of scale in larger practices, participation in negotiations in managed care contracts, improved hospital contracting terms and financial and professional security.

Therefore, for the ISMA to continue to meet the needs of its members in the future, we are going to be forced to decide what role, if any, organized medicine can play in the 1990s. The board of trustees, officers and executive management view the challenge to practicing physicians in the 1990s as an opportunity for growth. I look forward to the membership's active participation in the process.

TREASURER
John A. Bizal, M.D.

An unaudited report of receipts and expenditures and the state of funds on hand Sept. 30, 1992, is available during the sessions of the House and is referred to Reference Committee 1.

FIFTH DISTRICT
Fred Haggerty, M.D., trustee

The ISMA Fifth District has had regular quarterly meetings as well as its annual meeting. The quarterly meetings were fairly successful.

One quarterly meeting, which included legislators in the Fifth District, was well-attended. It gave physicians the opportunity to talk with legislators about issues that concern organized medicine, and the legislators seemed receptive.

Other quarterly meetings brought about concerns from our members, including AMA field representatives, the AMA hotline and what the AMA is doing for its members. Many members want AMA field representatives to visit and talk with them regularly, like drug representatives. Concerns about the ISMA's high cost of health care and liability insurance also were raised. Sentinel and other agencies also were discussed.

All members are encouraged to attend district meetings and the ISMA annual meeting. We need your input!

AD HOC TASK FORCE ON MEDICAL ECONOMICS
Michael Mellinger, M.D., chairman

Editor's note: Dr. Mellinger delivered this report as a speech at the opening session of the House of Delegates.

Good morning. As chairman of the Ad Hoc Task Force on Medical Economics, it is my responsibility to bring you up-to-date on two issues that have a great impact on health care delivery in Indiana ... the report of the State Health Policy Commission and the Indiana Compensation Act for Patients (INCAP).

As most of you know, for the past three years the State Health Policy Commission has studied Indiana's health care system, focusing specifically on access to health care, the cost of health care and preventive health care.

These studies have been carried out under the leadership of Ben Lytle, president of The Associated Group, the owner of Blue Cross/Blue Shield of Indiana.

The ISMA had no official representation at the table and no role in crafting the Health Policy Commission proposal.

The final report is due to Gov. Evan Bayh Nov. 1. ISMA staff has monitored the action of the State Health Policy Commission since its inception. Earlier this year, the ISMA Board of Trustees, following a resolution passed by the 1991 House of Delegates, appointed the Ad Hoc Task Force on Medical Economics to review the Health Policy Commission's draft report as well as other issues affecting the practice of medicine.

With that as an introduction, here is what the State Health Policy Commission is proposing:

As you can see, the proposal includes comprehensive health care reforms that would affect every participant in the present health care delivery system: physicians, insurers, hospitals, allied health providers, long-term care givers, employers and patients.

The proposal works to dissolve fee-for-service reimbursement and proposes capitated payment rates, provider salaries and fixed fee reimbursement strategies. Here's how the commission says the system should work:

Managed care is emphasized with primary care physicians responsible for directing patients through primary care, hospital and specialty care, long-term care and critical care. Primary care physicians, under the proposal, are responsible for formulating health care teams that may include other physicians as well as allied health professionals. To move through the system, all patients must be referred by primary care physicians. Patients could not seek specialty services without a referral except if they were willing to pay a higher copayment or deductible to bypass the system.

The primary health care team would contract with employers and group payors to provide services and would be reimbursed by salary or by a capitated rate.

Critical, catastrophic and terminally ill patients will be removed from the regular health care system into "systems of excellence." This is a small segment of the state's population, only 3% under age 65, but it consumes 37% of the state's health care budget, according to the draft report.

The systems of excellence would include hospitals and critical care teams. To be considered critical, catastrophically or terminally ill, patients must have either spent $250,000 on their health care or qualify by their illness. AIDS, pre-term birth, end-stage renal disease with dialysis, diabetes and cystic fibrosis are suggested qualifying illnesses.

Global budgets are proposed to curb costs. The commission recommends that employers and payors should convene individual policy panels to decide the level of financial resources and how those resources should be spent. The panels would include employees, management and state and community leaders.

Health care budgets should be set at 1% below the prior year's increase for each of the next 10 years, according to the draft report, until a rate equal to inflation is reached.

The policy panels would also be allowed to review new technology and determine which new services would be covered by their health plan. It would not be mandatory for the panel to seek assistance from medical experts in making these decisions.

Quality assessment would be addressed through a state-run not-for-profit corporation responsible for approving practice parameters for providers in the state. Actual review of practice parameters would be conducted by 15 separate clinical panels made up of consumers and physicians. Each would develop the standards of practice in specific health areas. Providers would not be required to follow the panel's standard-of-care guidelines.

Payors, however, will use the standards when reimbursing for care. Physicians who follow the standards will not be granted absolute defense in a resulting malpractice case.

Additional changes are sought in the current health care licensure system. All health care providers in the state would be licensed through a not-for-profit corporation. The corporation's board would be comprised of both professional and institutional providers plus a majority of consumers. Individual provider groups would be licensed by specialty boards, created by the corporation. The board would be responsible for receiving complaints, handling investigations and sanctioning providers and would establish continuing education and risk management requirements for providers.

The Health Policy Commission report calls for the proposed licensing corporation to establish a fraud and abuse unit. The unit would investigate cases of alleged provider fraud and abuse by soliciting information from payors and alerting payors to providers suspected of fraudulent or abusive activities. Physician ownership of health care facilities is addressed by citing several studies indicating that physician ownership re-

sults in over-utilization. The report seeks a law to require physician disclosure of ownership of health facilities.

With the Nov. 1 deadline bearing down on it, the Health Policy Commission, just last week, voted to recommend that the Office of Medicaid Policy and Planning study the feasibility of provider taxes. The tax is to be applied to as many providers as possible, including physicians, nursing homes and hospitals. The Medicaid director is already on record in support of such a tax.

Additionally, the commission called for exclusive provider contracts for Medicaid recipients.

I want to reiterate that the ISMA's role in the study process was limited to reactor.

Jean Terry, ISMA assistant director of government relations, attended each hearing as an observer.

Considering the historical tendency to shoot the messenger bearing bad news, I want to point out that Jean is living and well, and I sincerely hope I deserve the same fate.

One final point the Health Policy Commission report addresses is its support for the Indiana Compensation Act for Patients, which brings me to the second portion of the task force's presentation this morning.

INCAP has been a major ISMA focus for the past year. But the initial physician support for the law began more than 17 years ago. We have a videotape to fill you in on the history of INCAP and current ISMA initiatives.

There are a couple of footnotes to the videotape. As Dr. Beeson stated, we anticipate that critics will mount an all-out attack on INCAP this year. Efforts have been concentrated in an attempt to raise the cap on awards.

ISMA's position is that $750,000 escrowed and delivered in periodic payments allows the patient to receive considerably more than the $750,000 cap. This amount more than covers expenses for all but a fraction of 1% of injureds with a considerable amount remaining for non-economic damages.

The problem emerging nationally is that the system is consuming an ever increasing percentage of court awards. Nationally, 60 cents out of every dollar spent on medical negligence litigation goes for attorney fees and court costs.

Although hard data are not available, we know that provider premiums are lower in Indiana than in surrounding states. Thanks to a recent study by the IU School of Law's Professor Eleanor Kinney, we also know awards are higher in Indiana than in neighboring states. It seems likely, therefore, that a higher percentage of the awards finds its way to the patient in Indiana as opposed to the 40 cents on the dollar that patients receive nationally.

The Patients' Compensation Fund (PCF), funded entirely by health care providers, has served the patients of Indiana well, but to do this, it must remain solvent.

Something that is largely overlooked and underappreciated about the PCF is that it guarantees funds will be available to the citizens of Indiana. One of the major issues at a neighboring state's medical meeting last year was the doctor's right to go without insurance if its cost became prohibitive. Thus far, this has not been an issue in Indiana.

Another statistic I would like to see is what percentage of money awarded by the courts actually gets paid, not in malpractice litigation which we know in Indiana is 100%, but in other areas of liability. We read a lot of big numbers in the headlines, but I suspect child support is not the only area where funds mandated by the courts are just not received.

Often, discussions on INCAP are viewed as a doctor-lawyer struggle and that really is unfair. A very small percentage of attorneys are involved in medical malpractice litigation. Attorneys have their sub-specialists, too. I might say that medical malpractice plaintiff's attorneys are extremely well-represented among the leadership of the Indiana Trial Lawyers Association that represents the thrust for raising the cap. While very few attorneys are affected by INCAP, all health care providers, and more importantly, all citizens of Indiana who receive medical care are involved.

INCAP is not perfect, but it takes the best of a somewhat capricious system and makes it better for Hoosier patients. The sum of all of the elements of INCAP come together to serve the patients of Indiana. I believe we tamper with it at our own risk. ❑



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RESOLUTION 92-1A **Prohibit Corporal Punishment in Indiana Schools**

Introduced by: John W. Luce, M.D., LaPorte County
Referred to: Reference Committee 3
Action: Adopted Substitute Resolution 92-1A

RESOLVED, That current ISMA policy on corporal punishment be reaffirmed; and be it further

RESOLVED, That the ISMA encourage schools and licensed day care facilities to develop and implement effective, innovative, appropriate and positive behavioral management programs.

RESOLUTION 92-2 **Newsletter - AMA & Federal Activities**

Introduced by: James Rudolph, M.D., Putnam County
Referred to: Reference Committee 1
Action: Not Adopted

Whereas, Health care in the United States is rapidly changing; and

Whereas, The American Medical Association represents physicians in Washington, D.C.; and

Whereas, Indiana physicians need to be aware of AMA and federal activities that will have a direct effect on health care in Indiana; and

Whereas, There presently does not exist an effective means for AMA delegates to communicate with Indiana physicians; therefore be it

RESOLVED, That the ISMA in cooperation with Indiana AMA delegates create a quarterly newsletter for the purpose of keeping Indiana physicians informed of AMA and federal activities that will directly affect Indiana physicians.

RESOLUTION 92-3 **Dues Billing - Specialty Societies**

Introduced by: Timothy N. Brown, M.D., ISMA Assistant Treasurer
Referred to: Reference Committee 1
Action: Not Adopted

Whereas, At last year's convention there was an expressed interest in how dues are paid; and

Whereas, Specialty societies, the AMA, and ISMA all send dues statements at the year-end; and

Whereas, The future requires the Indiana State Medical Association to ease and assist practice management decisions; therefore be it

RESOLVED, That the administrative staff of ISMA design and implement a professional society, fee-payment schedule, billed and due other than year end (suggestion mid-year).

RESOLUTION 92-4 **Health Care in Nursing Facilities**

Introduced by: ISMA Section of Medical Directors and Staff Physicians of Nursing Facilities
Referred to: Reference Committee 1
Action: First Resolve Referred to Board of Trustees; Second Resolve Adopted

Whereas, The state of Indiana in conjunction with the U.S. government is responsible, through Medicaid, for the health care of the indigent and the elderly; and

Whereas, The continuation of such care in health facilities is placed in jeopardy due to failure to update per diem reimbursement in such facilities in relation to inflation; and

Whereas, OBRA requirements have not been addressed in updating per diem allowances; therefore be it

RESOLVED, That ISMA assist the Indiana Health Care Association's efforts to improve per diem reimbursement to better support adequate care of patients in health care facilities throughout the State of Indiana; and be it further

RESOLVED, That ISMA try again to revise regulations that require mandatory nutrition and hydration for patients in vegetative and/or terminal conditions, against medical advice.

RESOLUTION 92-5 **Legislation - Third-Party Payors**

Introduced by: Dearborn-Ohio County Medical Society and Fourth District
Referred to: Reference Committee 3
Action: Adopted as Amended

Whereas, Many of the actions of private third-party payors have served to interfere with the doctor-

patient relationships; therefore be it

RESOLVED, That the ISMA should seek legislation in the state of Indiana such that:

1. Legitimate medical claims by physicians and/or hospitals in good standing may not be arbitrarily denied if they are covered by the patient's insurance policy.

2. For insurance purposes, no physician or other health-care provider may declare a procedure or hospitalization to be "medically unnecessary" unless he or she has personally examined the patient.

RESOLUTION 92-6 **Physician Distribution**
Introduced by: Richard M. Spalding, M.D., Sellersburg
Referred to: Reference Committee 2
Action: Adopted as Amended

Whereas:

1. The number of primary care physicians (family practitioners, general internists, pediatricians, and obgyns) has been declining, especially in family practice, while the need is increasing; and

2. There is a physician maldistribution problem with a lack of primary physicians in rural areas and difficulty in subspecialists to venture out of urban areas; and

3. University medical training centers are often highly specialized tertiary care referral centers that often promote subspecialization through their training methods and role models; and

4. Several studies have demonstrated that primary care physicians usually utilize resources more efficiently than subspecialists in this time of spiraling health costs; and

5. Every other industrialized nation more efficiently utilizes primary care physicians as the backbone of their health care system compared to the United States; therefore be it

RESOLVED, That ISMA continue to work with the Dean of Indiana University Medical School, legislators, and other residency training directors in Indiana to develop a strategic plan to address the type of physicians, where they are needed, and methods to accomplish same; and be it further

RESOLVED, That ISMA work with the above in developing specific financial incentives to attract graduating medical students to primary care and rural practice.

RESOLUTION 92-7 **Medicare Reimbursement**
Introduced by: District 3
Referred to: Reference Committee 3
Action: Adopted as Amended

Whereas, Under the present Medicare reimbursement system, home visits by nurses are reimbursed at about twice the rate of physicians (about $60.00 compared to $30.00); therefore be it

RESOLVED, That:

ISMA interact with the regional Medicare carrier to explain and take action on the inequity of home visitation reimbursement for physicians; and

ISMA representatives present this issue to the AMA convention for action on a national level.

RESOLUTION 92-8 **ISMA's Annual Meeting Date**
Introduced by: Richard Huber, M.D., Bedford
Referred to: Reference Committee 1
Action: Referred to ISMA Board of Trustees

Whereas, The ISMA's annual meeting is scheduled for October 16-18, 1992; and

Whereas, the nation's largest medical specialty society, the American Academy of Family Physicians, also is conducting its annual meeting October 15-18; therefore be it

RESOLVED, That the Indiana State Medical Association make wholehearted efforts when scheduling the annual meeting to avoid conflicts with other major national medical society meetings.

Information:	Dates of future AAFP meetings
1993	Oct. 7-10 - Orlando
1994	Sept. 22-25 - Boston
1995	Sept. 21-24 - Anaheim
1996	Oct. 3-6 - New Orleans
1997	Sept. 25-28 - Kansas City
1998	Sept. 17-20 - San Francisco

RESOLUTION 92-9 **Committee to Nominate ISMA Officers**

Introduced by: Gordon Gutmann, M.D., Jeffersonville
Referred to: Reference Committee 2
Action: Not Adopted

Whereas, The efficient utilization of time at the annual Indiana State Medical Association meeting is desirable; and

Whereas, Other states have successfully utilized a nominating committee; and

Whereas, The leadership of the Indiana State Medical Association usually comes from trustees, officers, and house speakers; therefore be it

RESOLVED, That the Board of Trustees implement a nominating committee made up of appropriate members to nominate a slate of officers for the coming year, and also to accept nominations from the floor as has always been done in the past; and be it further

RESOLVED, That the ISMA Constitution and Bylaws be amended to incorporate this procedure to its text.

RESOLUTION 92-10A **Leadership Development Source for ISMA**

Introduced by: Thomas Brubaker, M.D., and Bernard Emkes, M.D.
Referred to: Reference Committee 1
Action: First Resolve Adopted; Second Resolve Referred to ISMA Board of Trustees

Whereas, Delegates to ISMA are a major source of organizational leadership development for ISMA,

Whereas, The Hospital Medical Staff Section of the American Medical Association is an excellent source of information about the modus operandi, benefits and actions of the AMA and an effective route of input into the AMA, therefore be it

RESOLVED, That the Indiana State Medical Association delegates and alternate delegates be requested to seriously consider representing their local hospital medical staff as delegates to the Hospital Medical Staff Section of the American Medical Association; and be it further

RESOLVED, That ISMA support biannual meetings for HMSS representatives from Indiana, if at least 20 representatives can be registered.

RESOLUTION 92-11 **Triplicate Prescription Law Repeal**

Introduced by: Susan Pyle, M.D.; Randolph County Medical Association
Referred to: Reference Committee 3
Action: Adopted Resolution 92-30 In Lieu of Resolution 92-11

Whereas, Physicians are reluctant to prescribe adequate pain medication because of the triplicate prescription law; and

Whereas, The triplicate prescription law has failed to identify abusers of drugs as it was intended; and

Whereas, This law is due for review and should have sunset provision; therefore be it

RESOLVED, That the Indiana State Medical Association actively petition the legislature to repeal the triplicate prescription law in the state of Indiana.

RESOLUTION 92-12 **Re-Establishment of "800" Medicare Number**

Introduced by: Lake County Medical Society
Referred to: Reference Committee 4
Action: Adopted

Whereas, Medicare must provide effective communications with providers to enhance efficiency; and

Whereas, Medicare communication from a provider can best be done via telephone; and

Whereas, An "800" telephone line was once provided by the Medicare carrier; and

Whereas, Under new regulations the "800" number can be eliminated; and

Whereas, The "800" number has been eliminated to the effect of discouraging communication with the Medicare carrier to resolve issues of benefit to the patient; therefore be it

RESOLVED, That ISMA petition the Indiana Medicare carrier and Medicare, that the "800" number (with sufficient lines) be re-established.

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RESOLUTION 92-13 **Simplification of Billing Procedures**

Introduced by: Broad Ripple Family Physicians
Referred to: Reference Committee 3
Action: Adopted

Whereas, The costs of medical care are ever increasing; and

Whereas, Many of these costs are related to billing expense, hassling with insurance plans and patients over co-payments and deductibles; and

Whereas, Many insurance companies have adopted the stance that a physician may not bill for co-payments or deductibles until after the insurance company has determined the allowable charges and remitted to the physician their covered amounts; and

Whereas, This may force the physician to not even bill the patient for 60-90 days after service, thereby hurting cash flow and further increasing costs by multiple billings, etc.; therefore be it

RESOLVED, That ISMA work with HMOs, PPOs, and standard insurance carriers in Indiana to develop or modify insurance products so that some simplification of this system can occur to ease the billing nightmare of physician offices.

RESOLUTION 92-14 **Medicare for Indiana**

Introduced by: Vigo County Medical Society
Referred to: Reference Committee 3
Action: Adopted

Whereas, The Medicare fee schedule, as applied to the various regions in the state of Indiana, is arbitrary and capricious; and

Whereas, Physicians practicing in more than one region are reimbursed according to the region where the service was rendered, causing confusion, delay and refiling; therefore be it

RESOLVED, That the Indiana State Medical Association House of Delegates recommend that there be a statewide Medicare fee schedule and that the state of Indiana be one Medicare region.

RESOLUTION 92-15 **Mandatory Computerization of Patient Records**

Introduced by: George Rawls, M.D., Indianapolis, ISMA Past President
Referred to: Reference Committee 1
Action: Adopted

Whereas, The administrative costs of health care are rising; and

Whereas, The AMA is participating in a work group for Electronic Data Interchange as indicated in Report EE from the AMA Board of Trustees (A-92); and

Whereas, Patient confidentiality may be compromised by Computerized Patient Records (CPR); and

Whereas, CPR in offices will expose physicians to utilization review without physicians' input; and

Whereas, CPR may be available to insurers, PRO and the National Data Bank; and

Whereas, CPR will increase physicians' overhead; therefore be it

RESOLVED, That Indiana physicians oppose mandatory computerization of their offices for Computerized Patient Records; and be it further

RESOLVED, That this resolution be presented by the Indiana Delegation to the American Medical Association at its Interim-92 meeting.

RESOLUTION 92-16 **Electronic Billing (EB)**

Introduced by: George Rawls, M.D., Indianapolis, ISMA Past President
Referred to: Reference Committee 4
Action: Adopted

Whereas, The physicians' overhead is increasing because of demands by third-party payors; and

Whereas, Electronic billing will further increase physicians' overhead; and

Whereas, Many physicians presently use the superbill and attach it to claims; therefore be it

RESOLVED, That Indiana physicians oppose mandatory electronic billing; and be it further

RESOLVED, That physicians not using electronic billing will not be penalized; and be it further

RESOLVED, That those physicians who choose to use electronic billing be compensated for the increase in office expense.

RESOLUTION 92-17 **Second Medical Opinions**
Introduced by: George Rawls, M.D., Indianapolis, ISMA Past President
Referred to: Reference Committee 2
Action: Adopted

Whereas, It is the right of patients to seek second opinions; and

Whereas, It is the prerogative of patients to select their physician in any clinical setting when given a choice; and

Whereas, The policy on second opinions of ISMA is in conflict with Report A (A-92) of the Council on Ethical and Judicial Affairs of the AMA; therefore be it

RESOLVED, That ISMA modify its policy on second opinions to be in concert with the policy of the AMA.

RESOLUTION 92-18 **Immunizations in Private Practice**
Introduced by: District 12 Medical Society
Referred to: Reference Committee 4
Action: Adopted Resolution 92-28 In Lieu of Resolution 92-18

Whereas, The immunization of children remains an extremely important part of preventive medicine provided by physicians for pediatric patients; and

Whereas, The present practice by the Indiana State Board of Health requiring all immunizations of children to be given at the Board of Health Office causes inconvenience to our patients, requiring them to make a separate trip to the Board of Health Office after their office examination; and

Whereas, This same practice causes inconvenience to our office employees who have to pull charts to record the date of the immunization after the information is received from the Board of Health; and

Whereas, Many physicians in the state of Indiana would prefer to give the immunizations to their patients, and would give the immunizations at no charge to the patients if the serum were provided by the Board of Health; therefore be it

RESOLVED, That ISMA work with the Indiana State Board of Health to change the present policy to allow every physician's office that desires to give immunizations to be provided with the serum by the Board of Health.

RESOLUTION 92-19 **ISMA Medical District Meetings & Elections**
Introduced by: ISMA Executive Committee
Referred to: Reference Committee 1
Action: Not Adopted

Whereas, An ad hoc Committee to Study District Meetings was formed in 1990 to make recommendations to the Board on how to improve attendance at district meetings; and

Whereas, The recommendations of that committee were presented to the Board and used by the trustees in the planning and implementation of their 1991 and 1992 district meetings; and

Whereas, Figures show that attendance at district meetings has not increased during 1991 or 1992; and

Whereas, Significant time and effort are spent by district officers, trustees/alternates and ISMA officers in planning and attendance at these annual business/social events; and

Whereas, The ISMA Constitution and Bylaws does not require that a specific "social" meeting of the district be held prior to the annual convention; therefore be it

RESOLVED, That the Board study and consider alternative methods of election for district officers, trustees, and alternates, through other means, and alleviate the need for annual district meetings.

RESOLUTION 92-20 **Family Violence**
Introduced by: John Knote, M.D., AMA Delegate, ISMA Past President
Referred to: Reference Committee 4
Action: Adopted

Whereas, Family violence has been named a major public health threat by the Centers for Disease Control; and

Whereas, Violence touches as many as one-fourth of all American families; and

Whereas, More than 2.4 million cases of child abuse were reported in 1989, making it one of the leading causes of injury and death in children, according to the National Committee for the Prevention of Child Abuse; and

Whereas, Three siblings in 100 use weapons on a sister or brother, meaning that 100,000 children in the United States annually face a brother or sister with a gun or knife in hand; and

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Whereas, As many as 4 million women are physically battered each year by husbands, ex-husbands and boyfriends, making domestic violence the single largest cause of injury to women in the United States; and

Whereas, More than 1 million older Americans are physically, financially and emotionally abused by their relatives each year; and

Whereas, The American Medical Association launched a National Campaign Against Family Violence to educate physicians about family violence and help them address the problem in their communities; therefore be it

RESOLVED, That the ISMA, in cooperation with the ISMA Auxiliary, participate in the AMA's National Campaign Against Family Violence by encouraging physicians to join the effort, by recommending establishment of local medical society violence prevention committees and by encouraging Auxiliary members to join the National Coalition against Violence; and be it further

RESOLVED, That the ISMA, in cooperation with the ISMA Auxiliary, encourage county auxiliaries to develop programs to educate the public about the family violence problem, to support the victims of family violence and provide physicians with lists of resource assistance for patients who are family violence victims; and be it further

RESOLVED, That these actions be undertaken with the approval of and in cooperation with the local county medical societies.

RESOLUTION 92-21 **Testing for Human Immunodeficiency Virus (HIV)**

Introduced by: Fort Wayne Medical Society
Referred to: Reference Committee 4
Action: Adopted as Amended

Whereas, *The New England Journal of Medicine* reported in August of 1992 that:

1. 1,000,000 American citizens are infected with the HIV virus and many are not aware of it;

2. 110,000 or 11% of those who carry the virus unknowingly could be identified in one year of hospital testing;

3. 200,000 HIV-infected patients are treated annually in the nation's 5,558 hospitals;

4. 134,000 HIV-infected patients treated in the nation's 5,558 hospitals will be treated for symptoms unrelated to this virus; and

Whereas, Early detection and treatment will benefit those who are infected and guard against their infecting others; and

Whereas, The highest incidence of HIV infection occurs between ages 15 and 54; and

Whereas, Physicians and health-care entities are required to go to great lengths to ensure the protection of others but are prevented by that same law (except under court order or emergency) to carry out the necessary steps of good, prudent, medical care and disease prevention due to informed consent laws and laws of confidentiality that prevent a physician from testing or informing emergency, nursing, surgical or other medical staff of a patient's HIV status; therefore be it

RESOLVED, That the ISMA petition the 1993 session of the Indiana General Assembly to pass legislation requiring hospitals to routinely offer voluntary HIV testing of all patients between the ages of 15 and 54 who are seen in Indiana hospitals.

RESOLUTION 92-22 **CLIA Regulations**

Introduced by: Fort Wayne Medical Society
Referred to: Reference Committee 1
Action: Adopted as Amended In Lieu of Resolution 92-23

Whereas, Final regulation of Clinical Laboratory Improvement Amendments of 1988 is now being implemented; and

Whereas, AMA official response has been formulated and forwarded to HCFA; and

Whereas, This official response articulated the general and specific concerns of the AMA membership; and

Whereas, CLIA regulations impact the ability of physicians to practice medicine, restricting diagnostic procedures that licensed physicians are qualified to do; i.e., among other examinations, urine microscopy, vaginal, prostatic and stool wet smear microscopy, rapid strep screens and hemoglobin by methods other than copper sulfate; and

Whereas, Public health programs are severely impacted by classifications of test complexity ruling; therefore be it

RESOLVED, That since a medical doctor is already licensed to perform some of the non-waivered

tests (i.e. urine microscopic examination, examination of the fluids from the vaginal vault, prostate, stool and semen, strep screens and hemoglobin determinations) that the ISMA ask the AMA to seek modification of CLIA regulation to exclude from regulation the tests that a physician by training would normally be capable of performing; and be it further

RESOLVED, That the Board of Trustees of ISMA study the effect of CLIA regulations on public health and nonprofit programs.

RESOLUTION 92-23 **CLIA Regulations**

Introduced by: Bartholomew-Brown County Medical Society

Referred to: Reference Committee 1

Action: Adopted Resolution 92-22, As Amended, In Lieu of Resolution 92-23

Whereas, Final regulation of Clinical Laboratory Improvement Amendments of 1988 is now being implemented; and

Whereas, AAFP official response has been formulated and forwarded to HCFA; and

Whereas, This official response articulated the general and specific concerns of the Academy and Society membership; and

Whereas, CLIA regulations impact the ability of physicians to practice medicine, restricting diagnostic procedures that licensed physicians are qualified to do; i.e., among other examinations, urine microscopy and vaginal, prostatic and stool wet smear microscopy; and

Whereas, Public health programs are severely impacted by classifications of test complexity ruling; therefore be it

RESOLVED, That since a medical doctor is already licensed to perform some of the non-waivered tests (i.e. urine microscopic examination, examination of fluids from the vaginal vault, prostate, stool and semen) that the ISMA and the AMA seek modification of CLIA regulation to exclude from regulation the tests that a physician by training would normally be capable of performing.

RESOLUTION 92-24 **Endorsement of "Standards for Pediatric Immunization Practices" & Its Adoption & Implementation By All Members**

Introduced by: John C. Bailey, M.D., Commissioner of Health, Indiana State Department of Health

Referred to: Reference Committee 4

Action: Adopted as Amended

Whereas, One of the most important national and state health objectives for the Year 2000 is to immunize 90% of preschool-aged children by their second birthday against diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps, rubella, *Haemophilus influenzae* type b and hepatitis B; and

Whereas, Indiana vaccination coverage data for preschool-aged children suggest that only about 60% of children are age-appropriately vaccinated by 2 years of age; and

Whereas, The National Vaccine Advisory Committee and a 35-member working group drawn from 24 different public and private sector organizations and numerous state and local health departments developed the "Standards for Pediatric Immunization Practices," and the United States Public Health Service approved and the American Academy of Pediatrics endorsed the "Standards" in May 1992; and

Whereas, The "Standards" are recommended for use by all health professionals providing care in public or private health care settings who are involved in the administration of vaccines or management of immunization services for children; and

Whereas, Current health practices fail to deliver vaccine on schedule to a large proportion of our vulnerable preschool-aged population, due in significant part to missed vaccination opportunities and barriers that impede vaccine delivery; and

Whereas, Changes in policies and practices can immediately improve vaccination coverage; and

Whereas, The "Standards" represent the most desirable immunization practices that health care providers should strive to achieve, and can serve as guidelines to help delineate ways in which immunization policies and practices can be enhanced and modified; therefore be it

RESOLVED, That ISMA endorse the "Standards for Pediatric Immunization Practices;" and be it further

RESOLVED, That the ISMA adopt and implement the "Standards" and ensure their distribution to all members, periodically updating them about the "Standards," with a survey by the Indiana State Department of Health.

RESOLUTION 92-25 **Due Process, Fair Hearing & Release of Selection Criteria by Managed Care Entities**

Introduced by: Vanderburgh County Medical Society
Referred to: Reference Committee 3
Action: Adopted

Whereas, Managed care entities offer a contractual arrangement whereby physicians who participate (or are invited to participate) are required to submit certain documentation of their credentials; and

Whereas, Because of the contractual nature of the arrangement, managed care entities are not required by law to release to physicians the criteria by which physicians are evaluated to determine whether or not the physician is denied or accepted by the managed care entity; and

Whereas, The physician has no recourse for denial of participation and the managed care entity is not required to provide a reason; therefore be it

RESOLVED, That the ISMA put forth a legislative initiative to require that any managed care entity who wishes to do business in Indiana be required by law to comply with the due process and fair hearing provisions of the Health Care Quality Improvement Act of 1986 and that all criteria used to determine physicians' acceptance by the managed care entity be released by the managed care entity to the physicians or his/her representatives in advance of or simultaneously with any participation document distribution.

RESOLUTION 92-26 **Consumer Advocate Within the State of Indiana Insurance Commission**

Introduced by: First District Medical Society
Referred to: Reference Committee 3
Action: Adopted as Amended

Whereas, Insurance companies frequently deny coverage for a physician-recommended mode of therapy for a particular patient; and

Whereas, Physicians and patients alike spend many hours communicating with the insurer in an effort to secure coverage; and

Whereas, There is no appeal mechanism (other than with the insurer who has an obvious financial interest) to assist in the interpretation of coverage within the insurance contract; and

Whereas, The Indiana legislature has historically regarded interpretation of contract coverage a "business decision" on the part of insurers; and

Whereas, The State Insurance Commission and the Indiana Department of Insurance serve in a regulatory capacity and are recognized as an authority in all matters of insurance; therefore be it

RESOLVED, That the ISMA pursue legislation that expands the scope of the Indiana Department of Insurance to include binding interpretation of coverage contracts; and be it further

RESOLVED, That the Indiana Department of Insurance employ a physician advocate who is familiar with the various insurance vehicles available and contractual coverage requirements so all parties may work through this physician advocate to pursue equitable resolutions to insurance coverage issues.

RESOLUTION 92-27 **Indiana State Health Policy Commission**

Introduced by: First District Medical Society
Referred to: Reference Committee 2
Action: Adopted

Whereas, The Indiana legislature mandated the formation of the Indiana State Health Policy Commission to study the health care system in Indiana and make recommendations to the legislature; and

Whereas, The governor made the physician appointments to the Indiana State Health Policy Commission without any input from ISMA; and

Whereas, At least one of these physicians will be leaving the state; and

Whereas, ISMA is most knowledgeable of the practice of medicine in Indiana and about which practicing physicians best represent the practice of medicine in Indiana; therefore be it

RESOLVED, That the ISMA pursue, either through agreement with the executive branch or through legislative action, approval of the physician representation on the Indiana State Health Policy Commission.

RESOLUTION 92-28 **Distribution of Childhood Vaccine**

Introduced by: First District Medical Society
Referred to: Reference Committee 4
Action: Adopted In Lieu of Resolution 92-18

Whereas, The existence of a nationwide federal contract allows public health departments and non-profit organizations that administer childhood vaccines to purchase the vaccines at the federal contract price; and

Whereas, Nationally 40% of all childhood vaccines are paid for through public funds while the remaining 60% of vaccines are funded by private payment; and

Whereas, An option exists in the federal contract to allow Medicaid providers to purchase vaccines for use on Medicaid patients at the federal contract price; and

Whereas, Indiana Medicaid reimburses physicians at the vaccine's wholesale price, which is less than the physician's cost to purchase the vaccines independently; and

Whereas, The Indiana State Department of Health is currently working to allow private providers to purchase vaccine for Medicaid patients at the contract price; and

Whereas, Indiana physicians are purchasing the vaccine at a cost that includes surcharges for the national childhood vaccine injury compensation fund; therefore be it

RESOLVED, That the Indiana State Department of Health continue to pursue allowing private physicians to purchase childhood vaccine for Medicaid patients through the federal contract at the negotiated prices; and be it further

RESOLVED, That the Indiana State Department of Health pursue federal contract expansion to allow physicians to purchase childhood vaccine at the federal contract price regardless of the patient population on which it is to be used; and be it further

RESOLVED, That the Indiana State Department of Health be encouraged to work toward some equitable distribution to physician offices within the state of childhood vaccine purchased at the federal contract price; and be it further

RESOLVED, That if none of these options are viable, that the state of Indiana provide childhood vaccine at no cost to all residents of the state.

RESOLUTION 92-29 **Indiana Residencies**

Introduced by: Vanderburgh County Medical Society
Referred to: Reference Committee 2
Action: Adopted as Amended

Whereas, The Indiana Commission for Higher Education will consider excusing of medical school tuitions in return for pledges by medical students to enter primary care practices in rural or underserved urban areas; and

Whereas, Indiana taxpayers support Indiana residency training programs by virtue of their taxes; and

Whereas, Some physicians who train in Indiana residency programs are from other states and have no intention of practicing in Indiana after completion of residency programs; and

Whereas, Some Indiana medical school graduates who wish to train in an Indiana residency program are turned down, even though they are well qualified for the program, in favor of a non-resident who often has no intention of practicing in Indiana; therefore be it

RESOLVED, That Indiana residency programs be encouraged to take qualified applicants from Indiana if they or their families are taxpayers in Indiana over non-resident applicants or those applicants who have no interest in ultimately practicing in Indiana.

RESOLUTION 92-30 **Triplicate Prescription Program**

Introduced by: Vanderburgh County Medical Society
Referred to: Reference Committee 3
Action: Adopted In Lieu of Resolution 92-11

Whereas, The Triplicate Prescription Program was enacted by regulation 845 IAC 1-1-1 et. seq., effective July 1, 1989, which set forth a program for the prescribing of Schedule II drugs; and

Whereas, Part of this program requires that physicians use specially developed, numerically-sequenced, triplicate forms provided by the state for the purpose of prescribing Schedule II drugs; and

Whereas, These forms are inconvenient to carry, due to their size and the concern that they may be lost; and

Whereas, The use of the triplicate prescription

form has resulted in a substantial decrease in the number of legitimate prescriptions for Schedule II drugs, resulting in patients not receiving needed drugs; and

Whereas, This law expires in July 1993 unless reactivated by the introduction of legislation in the 1993 legislative session; and

Whereas, Physicians are not opposed to the collection of prescription data provided it is collected at the appropriate level by the appropriate agencies; therefore be it

RESOLVED, That the current triplicate prescription program be ended and replaced with a program that allows for the collection and submission of data at the pharmacy level; and be it further

RESOLVED, That pharmaceutical manufacturers be enlisted to help with the demise of the triplicate prescription program as it is currently enacted as may be deemed appropriate by ISMA.

RESOLUTION 92-31 **Peer Counseling During Malpractice Litigation**

Introduced by: Rajih Y. Haddawi, M.D., Bloomington
Referred to: Reference Committee 1
Action: Adopted as Amended

Whereas, The number of malpractice claims in the state of Indiana has reached 8,373 since the year 1975; and

Whereas, Practicing medicine under the stress of a malpractice claim produces extraordinary tension, anxiety and depression to the physician and his or her family; and

Whereas, Malpractice claims frequently lead to the practice of defensive medicine, which adds to the increased cost of medical care; and

Whereas, Malpractice claims increase the dissatisfaction of the physician with his or her practice and patients, causing many physicians to limit the scope of their practice or into early retirement; and

Whereas, The majority of physicians in the state of Indiana have not been instructed in the steps necessary to provide a coping mechanism to deal with the disruption covered by malpractice litigation; therefore be it

RESOLVED, That the ISMA study the feasibility of establishing a physician support group for the purpose of providing peer counseling in the areas of emotional support - family stress and practice management - during malpractice litigation and report back to the 1993 House.

RESOLUTION 92-32 **Relinquish Medicare Filing Requirements for Non-Covered Services by Non-Participating Physicians**

Introduced by: C. Dyke Egnatz, M.D., Schererville, ISMA President
Referred to: Reference Committee 4
Action: Referred to ISMA Board of Trustees

Whereas, Medicare has ordered mandatory filing of claims by physicians on all transactions; and

Whereas, Non-participating physicians are required to obtain a signed waiver, explaining the patient's understanding and responsibility for non-covered services; and

Whereas, As the patient pays for the non-covered service, it remains a requirement to file a claim for the non-covered service that has been paid and is known to be denied in advance; and

Whereas, This superfluous filing is a further hassle directed at nonparticipating physicians as the patient will be further informed of that denial; therefore be it

RESOLVED, That paid, non-covered Medicare services with a filed waiver by the patient be exempt from Medicare filing when Medicare does not participate in any of the payment or reimbursement.

RESOLUTION 92-33 **INCAP Support & Publicity**

Introduced by: C. Dyke Egnatz, M.D., Schererville, ISMA President
Referred to: Reference Committee
Action: Adopted

Whereas, The professional liability legislation of Indiana has been properly entitled the Indiana Compensation Act for Patients (INCAP); and

Whereas, Indiana physicians have banded together to supply funds to guarantee payment of compensation to entitled parties; and

Whereas, Many states with exorbitant judgments are sensationalized but not realistically collectable or payable by the resources or insurance limits of the

judged defendant, resulting in little or no real compensation; and

Whereas, Indiana physicians contribute an amount 150% of their basic liability insurance premium to guarantee money for the Patient Compensation Fund; and

Whereas, Physicians in many similar-sized states pay premiums two or three times greater than Indiana, a cost that is transmitted to increased patient charges; therefore be it

RESOLVED, Each ISMA member actively educate his patients on the patient benefits protected by INCAP in regard to guaranteed payment of judgments and the benefit of controlling daily health care costs by this realistic legislation.

RESOLUTION 92-34 **Repeal of Federal & State Laws Creating & Legalizing Administrative Legal Proceedings in Courts**

Introduced by: C. Dyke Egnatz, M.D., Schererville, ISMA President
Referred to: Reference Committee 1
Action: Not Adopted

Whereas, All administrative legal proceedings deny the citizen his constitutional rights that are guaranteed in all other legal proceedings. These rights include, but are not restricted to: trial by jury, representation by counsel, protection against self-incrimination and double jeopardy and a presumption of innocence; and

Whereas, Administrative law judges are hired and paid for by the bureaucracy the citizen is in conflict with, thereby risking a biased judgment; and

Whereas, Administrative law proceedings are being used to unfairly attack and penalize physicians through state licensure boards, the U.S. Food and Drug Administration, the Environmental Protection Agency, the Health Care Financing Administration, the Occupational Safety and Health Administration, professional review organizations and the Federal Trade Commission; therefore be it

RESOLVED, That ISMA support any effort by the AMA to formulate and introduce to the U.S. Congress and to state legislatures model legislation to repeal administrative law and correct such unconstitutional controls.

RESOLUTION 92-35 **Repeal of McCarran-Ferguson Act**

Introduced by: C. Dyke Egnatz, M.D., Schererville, ISMA President
Referred to: Reference Committee 1
Action: Adopted as Amended

Whereas, The McCarran-Ferguson Act, 15 U.S.C., SS1011 et seq., was enacted in 1945 to insulate insurance companies and "the business of insurance" from the liability under the antitrust laws due to the fact that rates in the insurance industry then were set by multiple competitors appearing before state insurance commissioners; and

Whereas, The reason and justification for the insulation of the insurance industry and "the business of insurance" from liability under the antitrust laws no longer exists, since rate setting is no longer performed by insurance companies; and

Whereas, The insurance industry, as the payer for virtually every health care service rendered in the United States, is in a position to control - and in fact does control - most aspects of the delivery of health care; and

Whereas, Because of the continued visibility of the McCarran-Ferguson Act, insurers are able to share, and do share, payment and non-payment information with one another, as well as rate and price information and determinations regarding the form of health care delivery, which eliminates any and all competitive forces from the marketplace; and

Whereas, Physicians are subject to antitrust restrictions and penalties at the same time Medicare and the insurance industry can legally conspire to develop premium rates, fee schedules and payment limitations in their own self-interest; therefore be it

RESOLVED, That ISMA coordinate our support with any AMA action directed toward the McCarran-Ferguson Act.

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RESOLUTION 92-36 **Patient Compliance Rating**
Introduced by: C. Dyke Egnatz, M.D., Schererville, ISMA President
Referred to: Reference Committee 4
Action: Referred to ISMA Board of Trustees

Whereas, Physicians are more and more being penalized, criticized and often sued on the basis of medical outcome - morbidity and mortality; and

Whereas, The outcome of well-executed management or surgical procedures is greatly impacted by the basic health status of the patient, his/her social habits, educational level and cooperation; and

Whereas, Physicians are often unilaterally attacked by licensing boards, data bank entries, PROs, insurance plans, QA committees, without regard or inclusion of an opinion of the status or compliance of the individual patient involved; and

Whereas, Many well-meaning, responsible persons should be entitled to some liability protection for outcomes that are directly affected by irresponsible, antagonistic and non-compliant health care consumers; therefore be it

RESOLVED, That ISMA work through AMA, HCFA and the insurance industry to develop patient compliance rating scales in order to more effectively analyze patient access, utilization patterns, mortality and morbidity as a factor in health care cost and quality of care outcomes.

RESOLUTION 92-37 **Physician Assistants**
Introduced by: C. Dyke Egnatz, M.D., Schererville, ISMA President
Referred to: Reference Committee 4
Action: Referred to ISMA Board of Trustees

Whereas, Physician assistants are graduates of approved university training programs before being eligible for state certification; and

Whereas, Physician assistants require certification in order to serve in that capacity; and

Whereas, Physician assistants are under the employment and supervision of a licensed practicing physician in order to offer health care access to rural and underpopulated areas; therefore be it

RESOLVED, ISMA explore and monitor legislation proposed to clarify the authorization for certification of physician assistants in order to make utilization of such physician extenders available to practicing physicians.

RESOLUTION 92-38 **Increased Hospital Privileges for Primary Care Physicians**
Introduced by: C. Dyke Egnatz, M.D., Schererville, ISMA President
Referred to: Reference Committee 2
Action: Adopted

Whereas, Our medical care delivery system has been gradually divided into specialist/non-specialist and procedure/non-procedure physicians; and

Whereas, The current concurrent care restrictions imposed by Medicare has disrupted the continuity of the family physician's role, which is a significant attraction for new graduates to enter primary care; and

Whereas, At the same time, the proponents of managed care want the primary care gatekeeper to personally do more and more of all care and services, a schizoid contradiction of the previous "Whereas;" and

Whereas, Our medical delivery system is being fractioned into a two-tiered hospital/non-hospital division with a negative effect in attracting physicians into primary care; and

Whereas, Family practice residents spend three years to learn primary care procedures, obstetrical management, intensive care training, endoscopies and other enhancements to primary care, only to find those privileges controlled and restricted by the procedure specialists in the hospital setting; therefore be it

RESOLVED, That ISMA work with IAFP, IHA, and the School of Medicine to encourage hospital credentialing and privileging based on individual ability and personal request in addition to residence training in order to further attract physicians into family medicine and all primary care careers.

RESOLUTION 92-39 **Insured to Help the Uninsured**

Introduced by: C. Dyke Egnatz, M.D., Schererville, ISMA President
Referred to: Reference Committee 3
Action: Referred to ISMA Board of Trustees

Whereas, The individuals in our pool of uninsured change constantly due to the individual experience in hiring and lay-offs; and

Whereas, There is great social concern by the American people to address the health insurance needs of the uninsured, unemployed citizens; and

Whereas, Many state and local plans have been developed without adequate assessment of cost or funding; and

Whereas, The development of discriminatory taxes against populations such as health care providers is unfair; and

Whereas, Income tax revenues from health care benefits or allowances would uniformly and equitably supplement government income for Medicare, Medicaid and the unaffordably uninsured; therefore be it

RESOLVED, In order to improve revenue resources for the uninsured, ISMA work to seek legislation to require health care benefits to be a taxable compensation to the employee and in turn remain a tax-deductible, payroll expense to the employer.

RESOLUTION 92-40 **Satellite Medical Services**

Introduced by: C. Dyke Egnatz, M.D., Schererville, ISMA President
Referred to: Reference Committee 4
Action: Adopted as Amended

Whereas, There is a shortage and maldistribution of primary care physicians in Indiana; and

Whereas, Many underpopulated areas cannot support a medical practice in a local or nearby setting; and

Whereas, Physicians have an obligation and charge to offer medical services to all citizens; and

Whereas, Satellite or mobile offices in underserved areas staffed by physician assistants or nurse practitioners employed and supervised by a licensed, practicing physician would improve first-line access; therefore be it

RESOLVED, That the ISMA study the concept of utilizing physician extenders under the direction and supervision of a practicing physician to provide health care to appropriately defined underserved areas.

RESOLUTION 92-41 **Taxation of Health Care Benefits**

Introduced by: C. Dyke Egnatz, M.D., Schererville, ISMA President
Referred to: Reference Committee 3
Action: Referred to ISMA Board of Trustees

Whereas, Our medical care system is in severe market failure due to consumer demands in excess of resources or funding; and

Whereas, Government regulation often disrupts honest marketplace controls; and

Whereas, We need to restore a sound, honest marketplace in medicine, or medical care will become a controlled utility; and

Whereas, Industry and employers have no business paying insurance premiums for health care any more that it should pay insurance premiums for ACR, home or life insurance; therefore be it

RESOLVED, That ISMA work with state and national leaders to develop model legislation for all 50 states to repeal the law that allows benefits to be nontaxable to both employer and employee.

RESOLUTION 92-42 **Health Access Indiana**

Introduced by: Stephen Tharp, M.D., Frankfort
Referred to: Reference Committee 4
Action: Adopted as Amended; Referred to ISMA Board of Trustees

Whereas, It is important to the health of all Hoosiers that the Indiana State Medical Association participate in the debate on health care reform; and

Whereas, Indiana is experiencing a shortage of rural primary care physicians; and

Whereas, Part of the solution to this problem is increased support of medical education; and

Whereas, Medicaid continues to consume a larger part of the state's budget, yet the state has failed to seek a waiver from HCFA for a primary care case management system, as directed by the 1986 Indiana

General Assembly; and

Whereas, According to the study (Evaluation of Recent Changes in Medicaid) of six states who use case management systems, each state reported cost savings; and

Whereas, Despite the fact that Medicaid pays for services in Indiana at a considerably higher level than most states, physicians continue to withdraw from participating in the program due to hassles associated with administering the program; and

Whereas, No health care reform proposals currently being considered in Indiana call for insurance reform; and

Whereas, A basic "bare bones" insurance package with a high deductible would increase patients' financial participation, would encourage wise use of medical services, and would increase patients' access to insurance programs; and

Whereas, The ISMA House of Delegates is on record in support of a mandatory motorcycle helmet law; and

Whereas, The current law mandates helmets must be worn only by individuals under 18 years of age and does not appear to be adequately enforced; and

Whereas, Care for the majority of injured motorcyclists is paid for by public funds, according to a July 1988 study in *The Journal of the American Medical Association*; and

Whereas, No health care plan would be complete without addressing two major contributors to illness, alcohol and tobacco use; and

Whereas, The economic cost of alcohol use and abuse is projected to rise to $150 billion by 1995; and

Whereas, Alcohol tax policy appears to be more cost-effective as a countermeasure against highway fatalities than are drinking-age laws; and

Whereas, Legislation introduced to increase the tax on a pack of cigarettes with revenues going largely to fund health-related programs failed to pass the 1992 session of the Indiana General Assembly; and

Whereas, According to the General Accounting Office (GAO), a higher excise tax on cigarettes significantly reduces the number of smokers; and

Whereas, Revenues from "sin taxes" will increase funding and services of various state health programs; and

Whereas, A decrease in smoking and alcohol-related diseases would free resources now being spent on these illnesses and make them available for other necessary services; therefore be it

RESOLVED, That the ISMA participate in the debate on health care reform by introducing a Health Access Indiana bill in the Indiana General Assembly in 1993, or as soon as possible, that would include:

1. Incentives to attract and retain physicians in rural areas including loan forgiveness and deferrals and increased reimbursement levels;
2. Increased funding for graduate medical education;
3. Implementation of a care-managed program for Medicaid;
4. A reduction in physicians' Medicaid hassles;
5. Insurance reforms including a mandate for basic coverage with an income-adjusted deductible to ensure the wise use of services while providing a safety net for insured;
6. A mandatory motorcycle helmet law with no age restriction;
7. An increase in the state's alcohol and tobacco taxes; and
8. Insurance reform to guarantee that individuals can change jobs without losing health insurance coverage and without waiting periods, preexisting condition limitations, or premium increases due to health status.

RESOLUTION 92-43	**New Physician Reimbursement**
Introduced by:	Resident Medical Society
Referred to:	Reference Committee 3
Action:	Adopted as Amended

Whereas, Current Medicare guidelines include a four-to-five-year phase-in period for new physicians and physicians who have not previously billed on their own (i.e. military and certain group practices); and

Whereas, These payment limitations violate the spirit of the RBRVS; and

Whereas, Sen. John McCain (R-AZ) and Rep. Edolphus Town (D-NY) have introduced bills, S2362 and H4507 respectively, to repeal laws that mandate these reductions in Medicare reimbursements; therefore be it

RESOLVED, That the ISMA support legislation that calls for repeal of the current Medicare repayment schedule for new physicians; and be it further

RESOLVED, That the ISMA request its delegates and members to contact their respective congressmen

to express support for such legislation.

RESOLUTION 92-44 **Resident Membership**
Introduced by: Resident Medical Society
Referred to: Reference Committee 1
Action: Adopted

Whereas, Since its beginning in 1985, the total membership of ISMA Resident Medical Society has steadily declined; and

Whereas, At least 50% of resident members are lost via non-renewal of membership after the first year of residency; and

Whereas, Early exposure to and involvement in organized medicine is important for securing informed active leaders for the future of medicine; and

Whereas, AMA-MSS and AMA-RPS have begun to offer multi-year memberships at a slightly reduced rate with success; therefore be it

RESOLVED, That the ISMA develop a multi-year membership program for residents that would allow for a one-time-membership fee for a resident's entire residency, so long as residency years are consecutive.

RESOLUTION 92-45 **Optometric Prescribing Liability**
Introduced by: Paul Honan, M.D., Lebanon
Referred to: Reference Committee 1
Action: Adopted as Amended

Whereas, Physicians in Indiana have the necessary education and clinical training to prescribe all drugs; and

Whereas, The use of drugs is not just organ-related but affects the whole person; and

Whereas, The Optometric Legend Drug Prescription Advisory Committee (OLDPAC) promulgated rules requiring notification of a physician concerning the prescribing of legend drugs by an optometrist; and

Whereas, This notification comes after the legend drug has been prescribed; and

Whereas, This notification also makes the physician responsible and liable for effects and results of the legend drugs without having seen the patient; and

Whereas, The formulary promulgated by OLDPAC includes many drugs not normally used by most physicians; and

Whereas, Optometrists do not have the training and clinical experience necessary to diagnose and treat serious eye diseases; therefore be it

RESOLVED, That the ISMA Board of Trustees should seek appropriate legal advice on the transfer of liability to physicians that was created by the optometric prescribing law; and be it further

RESOLVED, That this information should then be disseminated to the ISMA membership through all available means; and be it further

RESOLVED, That if no appropriate legal solution can be found, the ISMA should seek legislative action to remove such transfer of liability.

RESOLUTION 92-46 **Delegation of Medical Authority by Physicians**
Introduced by: Ralph Stewart, M.D., Vincennes
Referred to: Reference Committee 1
Action: Adopted

Whereas, Many paramedical provider groups are attempting to broaden their scope of practice; and

Whereas, Many of these groups are not adequately trained to perform all aspects of medical care; and

Whereas, The quality of care Indiana patients are receiving may be compromised; and

Whereas, Some surgeons are delegating post-operative care to paramedical personnel not trained in surgical care; and

Whereas, The Medical Licensing Board is currently studying the scope of practice of nurse practitioners and requests from physician assistants to prescribe; and

Whereas, The Medical Licensing Board has the authority to regulate a physician's delegation and supervision; therefore be it

RESOLVED, That the ISMA should form an ad hoc committee to make recommendations to the Medical Licensing Board regarding physician supervision and delegation of duties to paramedical personnel.

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RESOLUTION 92-47 **Mandatory Referral Criteria**
Introduced by: Ralph Stewart, M.D., Vincennes
Referred to: Reference Committee 1
Action: Adopted as Amended

Whereas, Paramedical personnel are not adequately trained to perform all aspects of medical care; and

Whereas, The scope of practice of paramedical personnel is expanding; and

Whereas, The scope of practice should be determined by training and not by legislative fiat; and

Whereas, Third-party payors are beginning to turn to paramedical personnel to provide medical care because of financial reasons rather than quality reasons; and

Whereas, Paramedical groups continue to seek expansion of their practices into areas that include parameters uniquely limited to the education and training of a physician; therefore be it

RESOLVED, That the ISMA should form an ad hoc committee to study mandatory referral criteria for paramedical personnel and report its findings to next year's House of Delegates; and be it further

RESOLVED, That the ISMA continue to oppose the practice of medicine by individuals without an unlimited license.

RESOLUTION 92-48 **Recommendation for the Use of Polycarbonate Clear Face Guards Worn by All Baseball Players in Organized Baseball, Ages 5-14**
Introduced by: Stephen W. Perkins, M.D., Indianapolis Medical Society; Mason Bell, Indiana Society to Prevent Blindness; the National Society to Prevent Blindness; and the American Academy of Facial Plastic and Reconstructive Surgery
Referred to: Reference Committee 4
Action: Adopted

Whereas, According to the consumer product safety commission, there were over 1.3 million cases of injuries to the face, eyes and mouth treated in the United States emergency rooms for patients less than 15 years old; and

Whereas, Over 130,000 of these cases were major facial bony trauma including nasal fractures for those patients under the age of 14 participating in sporting activities in 1990 alone; and

Whereas, The largest documented number of injuries to the face have occurred to the mouth and dental area with the greatest frequency in baseball-related activities; and

Whereas, Severe and multiple ocular injuries have been documented to date. The National Society to Prevent Blindness and its affiliates, including the Indiana Society to Prevent Blindness, have recognized and documented the relatively high instance of eye injuries in sports - primarily in the 5-15 age group playing baseball; and

Whereas, The American Academy of Facial Plastic and Reconstructive Surgery, through a survey to their members on sports-related facial trauma in children, has documented 40% of sports injuries to the face were in the 5-14 age group; and

Whereas, Baseball-related injuries far exceed all other sports in causing death. In the 5-14 age group, 40 of 105 reported sports-related fatalities in children were the result of a baseball being hit by a struck bat or ball, and two-thirds of the baseball deaths were the result of injuries to the face and head region; and

Whereas, 65% of all injuries to the face in children under 18 years of age involved nasal fractures; and

Whereas, Softball, because of its increased mass, is documented to show even more devastating injuries to the under-15-year-old age group than even the hard baseball; and

Whereas, It has been shown that children under 15 have poor response times with reflexes and a lower level of skill, as compared with those older than 15; therefore be it

RESOLVED, That the Indiana State Medical Association, on behalf of the National Society to Prevent Blindness, the American Academy of Facial Plastic and Reconstructive Surgery and the Indianapolis Medical Society, advocate the use of polycarbonate face guards as a permanent installation of the current bilateral ear protective batter's helmet, to be worn by all baseball and softball players as required safety equipment in all organized baseball and softball for those children from 5-14 years of age. Specifically, this polycarbonate face guard should be mandatory for all batters and pitchers, with the strong recommendation that outfielders be included in this group.

RESOLUTION 92-49 **Allow Competitive Physician Salaries Despite "Safe Harbor" Regulations**

Introduced by: Alvin J. Haley, M.D., Indianapolis Medical Society
Referred to: Reference Committee 3
Action: Adopted as Amended

Whereas, the Federal Internal Revenue Service has "Safe Harbor" regulations that disallow not-for-profit hospitals offering physicians' salaries above the normal or average salaries and benefits earned by physicians in that community; and

Whereas, The IRS threatens to remove a not-for-profit hospital's favorable tax advantage if it appears the hospital is violating the "Safe Harbor" rules of the Health and Human Services Department Office of the Inspector General; and

Whereas, This enforcement of "Safe Harbor" regulations tends to place a cap on physicians' salaries and benefits; and

Whereas, The purpose of "Safe Harbor" regulations is to prevent fraud and abuse - not regulate physicians' incomes; now therefore be it

RESOLVED, That the Indiana State Medical Association ask the AMA to pursue political and/or legislative repeal of the IRS portion of the "Safe Harbor" regulations that discriminate against not-for-profit hospitals. ❑

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ISMA Fifty Year Club

Last year, 86 physician members were honored by the Indiana State Medical Association in recognition of their 50 years of service as loyal and devoted practitioners of medicine. These new members of the Fifty Year Club will join the roster of other distinguished Hoosier physicians inducted into the Fifty Year Club since its inception in 1948.

The ISMA wishes to formally acknowledge the following physicians for their unselfish service to their patients and profession:

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Auxiliary offers help with mini-internship program

Trudy Urgena
ISMA Auxiliary President

Health care reform has become the legislative issue of the '90s. To be able to favorably influence the outcome of health care legislation, especially on the state level, grassroots physicians and their spouses must become involved in the legislative decision-making process.

The mini-internship program is ideal for involving both the medical society and its auxiliary in educating legislators about the realities of medicine and health care delivery. Endorsed by the American Medical Association (AMA), the mini-internship program is designed to help legislators and community leaders understand the pressures and concerns of physicians. Done at the county level, the mini-internships offer a firsthand opportunity for people who affect, implement or report on health care policy to experience the daily practice (and frustrations) of medicine.

Benefits of this firsthand experience include:

- promoting understanding through personal experience;
- informing the legislator of problems in health care delivery;
- countering any inaccurate preconceptions legislators may have regarding health care delivery; and
- creating a future physician resource for the legislator.

What better way for grassroots physicians to become involved in the legislative decision-making process than to do what they do best: caring for patients? The only difference would be a legislator "intern" shadowing them during a typical day to learn the realities of medical care.

The role of the county auxiliary, in counties without medical society executive staff, is overall administration and implementation of the mini-internship program. After the medical society identifies participants, the auxiliary presents the orientation session and explains the program.

The AMA's resource book *How to Start a Mini-Internship Program* is a step-by-step guide for county medical societies and auxiliaries to use in planning, scheduling and coordinating a Mini-Internship Program. *How to Start a Mini-Internship Program* is available with a video that presents scenes from an actual program.

The mini-internship program has been successful in numerous states, including Ohio, Illinois, Iowa and Oregon. Allen and Vanderburgh county medical societies have successfully conducted the mini-internships in Indiana.

The mini-internship program can be implemented regardless of county medical society size and is adapted to the needs and resources of each medical society and auxiliary.

In today's health care environment of spiraling costs, criticism, litigation and misunderstanding, the mini-internship program is an opportunity to address these concerns. This high-impact community relations program creates the atmosphere for positive attitude changes through personal experience.

The ISMA Auxiliary is instructing county auxiliaries on how to assist local medical societies in implementing the mini-internship program. ❑

County auxiliary legislative activities

The flurry of election season is over, and as the dust settles, it is time to recoup, take stock and plan for our legislative future. Our emphasis since May has been on voter registration and many, if not most, of our county auxiliaries have participated in this effort. Tippecanoe County registered all its new physicians and spouses, and Delaware/Blackford, Allen and Lloyd counties also undertook major registration initiatives.

Allen County held their annual Legislative Forum, which was well-attended by legislative candidates and the medical community. Vanderburgh and Clark counties held joint auxiliary/medical society dinners with legislative focus and forums.

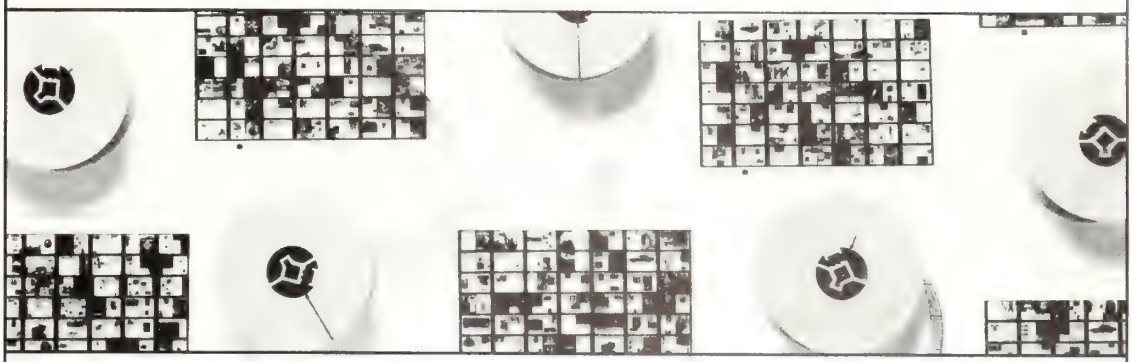
Betty Wolverton, ISMA Auxiliary legislative co-chair, provided a legislative information booth at the ISMA convention in October. Andy Kuipers, ISMA Auxiliary co-chair, attended the Legislative Forum on Social Concerns held at the Westin Hotel on Nov. 17.

Delaware-Blackford will start their Legislative Study Group with the beginning of the state legislative session. Bartholomew-Brown is reactivating their phone tree.

Day At The Capitol will be Feb. 17 at the Embassy Suites in downtown Indianapolis. Physicians are encouraged to attend.

Topics will include how to organize for legislative effectiveness, lobbying your legislator, planning and implementing a county legislative mini-internship program and a legislative update. ❑

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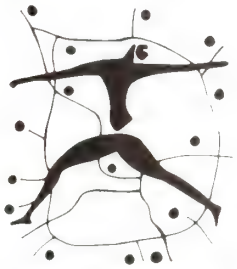
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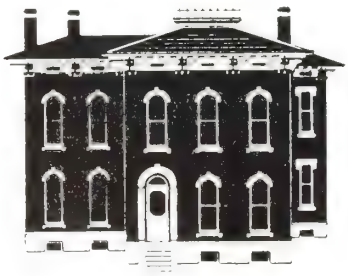
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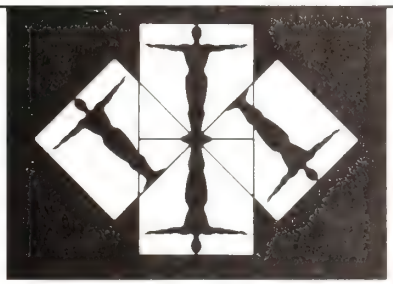
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The introduction of vulcanite in 1851 not only brought the cost of artificial teeth within reach of the masses but also revolutionized how dentists made dentures.

Most people could not afford artificial teeth until Nelson Goodyear, the brother of rubber magnate Charles Goodyear, discovered a technique to change flexible rubber into a hard unyielding substance that Nelson Goodyear named vulcanite. After this discovery, vulcanite replaced gold as the material that dentists preferred for the construction of denture bases.

Besides its strength and durability, vulcanite possessed the qualities of lightness, insolubility in oral secretions and an imperviousness to fluids. In addition, a dentist could color vulcanite by injecting vermilion, a sulphuret of mercury, into the rubber compound before vulcanization – the application of intense heat to harden rubber and other compounds.

The introduction of vulcanization and the discovery of vulcanite enabled dentists to produce artificial teeth again. The time required to make dentures had prompted most dentists by the early 1800s to take impressions of the patients' mouths and then employ craftsmen to produce acceptable dentures.

However, exposure to the techniques of vulcanization prompted dentists to retain their impressions and make the artificial teeth in their offices. This technology provided dentists with more control over the production of dentures for their patients.

After making an impression of a patient's mouth with plaster of Paris, a dentist used gutta-percha or another modeling compound to create temporary base plates for the upper and lower gums. The dentist typically saturated the impressions with cold water to prevent any adhesion that might occur when the dentist heated the modeling compound to form the base plates.

Having arranged and adjusted the artificial teeth properly, the dentist attached the teeth to the temporary base plates by platina pins contained inside the teeth. Throughout the 1800s, dental companies supplied dentists with these artificial teeth, manufactured primarily from ivory and, then increasingly, from human teeth removed from corpses.

Once each temporary base plate was completed, the dentist used a vulcanizing flask to form the necessary matrix or mold. The box-shaped flask, which required screws to hold the various parts together, consisted of a lower section sealed on one end, an upper section opened on each end and a lid.

After partially filling the flask's lower section with plaster, the dentist placed a temporary base plate into the flask, ensuring that the plaster did not rise too far. Leaving the teeth untouched, the dentist then oiled the visible parts of the temporary base plate.

Once the flask's upper section was in place, the dentist filled the flask with plaster, clamped the lid onto the flask and heated the entire container sufficiently to soften but not melt the gutta-percha. When the dentist separated the flask's upper and lower sections, the temporary base plate remained attached to the flask's lower section while the teeth remained affixed to the flask's upper section.

The dentist then heated the flask's upper section enough to apply narrow strips of the rubber compound around the platina pins. Using a single piece of rubber to form the palatial convexity, the dentist finished packing the flask's upper section, carefully removed the temporary base plate from the flask's lower section, reassembled the flask's two sections in their original positions and placed the sealed flask into a vulcanizer, which applied intense heat to harden the rubber compound.

The Indiana Medical History Museum currently explores vulcanization and other contributions Americans have made to the development of professional dentistry in an exhibit titled "Americans in a New Age of Dentistry." Tourists may visit the museum, located on the grounds of Central State Hospital in Indianapolis, from 10 a.m. to 4 p.m., Wednesdays through Saturdays, and at other times by appointment. ❑

Sources: 1) Malvin E. Ring, D.D.S.: *Dentistry: An Illustrated History,* (1985) and 2) Joseph Richardson, M.D., D.D.S.: *A Practical Theatre on Mechanical Dentistry,* (1893).

cme calendar

Aesthetic Surgery

The 1993 Aesthetic Surgery of the Aging Face seminar will be held March 3 through 7 at the Radisson Hotel in Indianapolis. The seminar is sponsored by Beeson Facial Plastic & Reconstructive Surgery in Indianapolis and the American Academy of Facial Plastic & Reconstructive Surgery.

For more information, call Carrie Van Dyke, (317) 846-2988.

Nasser, Smith & Pinkerton

Nasser, Smith & Pinkerton Cardiology in Indianapolis will present Echocardiography 1993: Practical Applications for Clinicians March 5 at the Ritz Charles in Carmel.

For more information, call Janet MacAbee, (317) 871-6089.

Reid Hospital

Reid Hospital & Health Care Services in Richmond will sponsor the Third Annual Pediatric Seminar on the Treatment of Pediatric Emergencies Feb. 16.

For more information, call Marie Hopper, (317) 983-3112.

Indiana University

The Indiana University School of Medicine will sponsor these courses:

Feb. 13-14 – Annual Meeting of the Indiana Society of Anesthesiologists and Anesthesiology Update, Westin Hotel, Indianapolis.

Mar. 1 – Advances in Craniomaxillofacial Surgery, University Place Conference Center, IUPUI campus, Indianapolis.

Mar. 3 – Routing Prenatal Evaluation for Congenital Heart Disease, Omni Severin, Indianapolis.

Mar. 10 – Focused Seminar on Rhinitis and Sinusitis for the Primary Care Physician, Radisson Plaza & Suite Hotel, Indianapolis.

Apr. 4-6 – 1993 Symposium on Breast Imaging, University Place Conference Center, Indianapolis.

Apr. 23 – 16th Annual Arthur B. Richter Conference in Child Psychiatry, University Place Conference Center, Indianapolis.

Apr. 26-28 – Update Workshop in Echocardiographic Techniques, University Place Conference Center, Indianapolis.

Apr. 30 – Advances in Urological Oncology, Myers Auditorium, IUPUI campus, Indianapolis.

Apr. 30-May 1 – Minimally Invasive Surgery and Its Complications, University Place Conference Center, Indianapolis.

For more information, call Liza Beaty, (317) 274-8353.

Methodist Hospital

Methodist Hospital of Indiana in Indianapolis will sponsor these CME courses:

Feb. 5 – Occupational Medicine Conference, Methodist Hospital, Indianapolis.

Mar. 6 – Cardiology Update 1993, University Place Conference Center, Indianapolis.

Mar. 12-13 – Pelvic Floor Electrodiagnosis, San Diego Marriott Hotel & Marina, San Diego, Calif.

Mar. 17-18 – Pediatric Critical Care, Hyatt Regency, Indianapolis.

Mar. 26-27 – ATLS (tentative), Methodist Hospital, Indianapolis.

Apr. 30 – Behavioral Care, Omni Severin, Indianapolis.

May 12 – Toxicology, Adam's Mark Hotel, Indianapolis, sponsored in conjunction with the Indiana Chapter American College of Emergency Physicians.

May 14-15 – Medicine & Political Controversies in Vascular Disease, Radisson Hotel, Indianapolis.

For details, call Mary Pate, (317) 929-3733.

Indpls. Regional Heart Center

The Indianapolis Regional Heart Center at St. Francis in Beech Grove will sponsor these CME courses:

Feb. 27-28 – Cardiology Update 1993, Hyatt Regency, Indianapolis.

Mar. 24-25 – Cardiac Refresher Course: Invasive Cardiology.

Apr. 8 – Cardiac Refresher Course: Non-invasive Cardiology.

Apr. 22 – Cardiac Refresher Course: Non-invasive Cardiology.

Apr. 28-29 – Cardiac Refresher Course: Cardiac Care.

For more information, call Brandon Roger (317) 783-2776. ❑

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Ambulatory walk-in clinics in Lafayette and West Lafayette supplement primary clinic services. Arnett Urgent Care Centers are open from 8 a.m. until 8 p.m. every day, and staff members provide diagnosis and treatment for any medical problem which does not require ambulance transport.

Arnett physicians provide hospital support services at two nearby community hospitals, Home Hospital with 365 beds, and St. Elizabeth Hospital with 375 beds. Arnett has diversified into other healthcare fields, including Arnett Health Systems (an HMO) and the corporate affiliates of Arnett Medical Supply and Arnett Pharmacy.

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Practice Setting

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Benefits

Our Medical Staff members enjoy competitive salaries and a generous benefit package. During the first two years of employment, Arnett offers a guaranteed minimum salary with a production bonus. After two years of successful practice experience, shareholder status with a productivity incentive formula is available. An excellent profit-sharing and investment plan is also available.

Other benefits include health coverage via Arnett HMO or other group insurance, disability, and life insurance plans. A generous fund for continuing education is available to clinic physicians.

Community

Lafayette, Indiana is a thriving, low-crime community located in a county of approximately 132,000 people. Purdue University, known for academic leadership in the areas of engineering, agriculture, humanities, and sciences, and for Big Ten Sports, is nearby. *Money Magazine* recently identified Lafayette as one of the top 14 cities in which to live in the U.S.A.

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obituaries

Ivan F. Bennett, M.D.
Dr. Bennett, 73, an Indianapolis psychiatrist, died Nov. 9 at his home.

He was a 1944 graduate of Jefferson Medical College of Thomas Jefferson University in Pennsylvania and a veteran of the Army Medical Corps.

Dr. Bennett was director and senior physician at Lilly Laboratories for 27 years, retiring in 1985. He also was an associate staff physician at Wishard Memorial Hospital and a professor of psychiatry at the Indiana University School of Medicine. He previously worked for State Hospital in Harrisburg, Pa., and Veterans Hospital in Coatsville, Pa., before becoming chief of psychiatric research at Veterans Hospital in Washington, D.C. Dr. Bennett was a fellow of the American College of Physicians and a member of the American Psychiatric Association and the American College of Neuropsychopharmacology.

Milton V. Caldwell, M.D.
Dr. Caldwell, 76, a retired Terre Haute radiologist, died Oct. 12 at St. Vincent Hospital in Indianapolis.

He was a 1939 graduate of the State University of New York at Buffalo and an Army veteran.

Dr. Caldwell was a radiologist for 50 years, retiring from Wabash Valley Radiologists in 1984. He was a diplomate of the American Board of Radiology and a member of the Radiological Society of North America.

F.R. Nicholas Carter, M.D.
Dr. Carter, 100, a former South Bend health officer, died Nov. 15 at his home in South Bend.

He was a 1921 graduate of the Indiana University School of Medicine.

Dr. Carter was city health officer for many years, beginning in 1935. He also was director of the U.S. Public Health Clinic, the Indiana Public Health Association and the St. Joseph County Cancer Society. He retired from his medical practice in 1961.

Clarence E. Ehrlich, M.D.
Dr. Ehrlich, 54, chairman of the department of obstetrics and gynecology at the Indiana University School of Medicine, died Oct. 30.

He was a 1965 graduate of the Baylor College of Medicine and an Air Force Medical Corps veteran.

Dr. Ehrlich was the William H. and Sallie E. Coleman Professor at I.U. He joined the faculty in 1973 as director of the section of gynecologic oncology and was named chairman of the department in 1981. He made internationally significant research contributions to the field of gynecologic oncology, such as studies on the diagnosis and treatment of endometrial and ovarian cancers. He was executive director-elect of the American Board of Obstetrics and Gynecology and director of the board's Division of Gynecologic Oncology. Dr. Ehrlich was president of the Indiana Section of the American College of Obstetricians and Gynecologists and had been president of the Society of Gynecologic Oncologists and the Felix Rutledge Society.

Donald H. Ferguson, M.D.
Dr. Ferguson, 69, an Anderson internist, died Sept. 23 at St. Vincent Hospital in Indianapolis.

He was a 1949 graduate of the University of Virginia School of Medicine and a veteran of the U.S. Air Force and the U.S. Army.

Dr. Ferguson was an internist in Anderson for the past 35 years and had been on the staff at St. John's Medical Center. He was a member of the American Society of Internal Medicine.

Roy L. Fultz, M.D.
Dr. Fultz, 67, a retired Jeffersonville anesthesiologist, died Sept. 13 at Clark Memorial Hospital.

He was a 1953 graduate of the Indiana University School of Medicine and a Navy veteran of World War II.

Dr. Fultz had a general practice in Salem for 16 years, was an anesthesiologist in Clark County for 19 years and was Washington County coroner from 1968 to 1972.

Charles E. Geckler, M.D.
Dr. Geckler, 75, a retired Muncie pathologist, died Oct. 18 at his home.

He was a 1942 graduate of the Ohio State University College of Medicine.

Dr. Geckler was a general practitioner in Ohio before moving to Muncie in 1949 to practice pathology. He and his wife operated a Christmas tree farm in northeastern Delaware County for more than 30 years.

Herman Hepner, M.D.
Dr. Hepner, 64, a Kendallville family physician, died Nov. 6 at his home.

He was a 1952 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Hepner had been a physician in Kendallville since 1953, retiring in 1991, and along with another doctor and a dentist, built the city's Medical Arts Clinic. His

mother, father, grandfather and two uncles were physicians. He and his wife were avid motorcyclists and also collected snakes, which they showed to children during visits to area schools.

Robert P. Lloyd, M.D.
Dr. Lloyd, 73, a former Fort Wayne surgeon, died Sept. 5. He was living in New Smyrna Beach, Fla., at the time of his death.

He was a 1944 graduate of the Indiana University School of Medicine and an Army Medical Corps veteran.

Dr. Lloyd was a general, thoracic and cardiovascular surgeon in Fort Wayne from 1951 to 1983. He was a fellow of the American College of Surgeons and a past president of the Indiana Heart Association.

Roland E. Miller, M.D.
Dr. Miller, 77, a retired West Lafayette pediatrician, died Sept. 1 in St. Elizabeth Medical Center in Lafayette.

He was a 1940 graduate of the Indiana University School of Medicine and an Army Medical Corps veteran of World War II.

Dr. Miller was a pediatrician for 37 years in the Lafayette area and was school physician for the Lafayette School Corp. for 30 years before retiring in 1988. He was a past president of Home Hospital and St. Elizabeth Hospital Medical Center medical staffs and was state chairman of the Indiana Chapter of the American Academy of Pediatrics from 1964 to 1970.

Paul W. Schmiedicke, M.D.
Dr. Schmiedicke, 91, who had served as the Purdue University Student Health Center physician, died Nov. 10 at the Mulberry (Ind.) Lutheran Home.

He was a 1931 graduate of the University of Wisconsin Medical School.

Dr. Schmiedicke had been the health officer for West Lafayette.

Julius T. Steffen, M.D.
Dr. Steffen, 93, a retired Wabash family physician, died Oct. 9 at his home.

He was a 1941 graduate of the Indiana University School of Medicine and an Army veteran of World War I.

Dr. Steffen was a family physician in Wabash for 37 years. He was a member of the American Academy of Family Physicians and had served on the Wabash County Hospital board of directors and the Wabash County Board of Public Health. In 1968 he was named "Man of the Year" by the Presbyterian Church, and in 1975 he received the Kiwanis Club Legion of Honor degree for 30 years of service.

Howard S. Williams Jr., M.D.
Dr. Williams, 82, a retired Indianapolis emergency physician, died Sept. 27 at St. Vincent Hospital in Indianapolis.

He was a 1936 graduate of the Tulane University School of Medicine and an Army Medical Corps veteran of World War II.

Dr. Williams was in private practice 20 years before joining the emergency department staff at Community Hospital in Indianapolis. There he helped establish a full-time emergency department for physicians, the first in Indiana. He served on former Gov. Otis Bowen's Emergency Medical Commission. ❑



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Drs. William J. Berg and **Thomas D. Hughes**, members of Indiana Heart Physicians in Indianapolis, were elected fellows of the American College of Cardiology.

Dr. Frederick M. Kelvin, an Indianapolis radiologist, spoke on radiographic evaluation of the pelvic floor during a conference on pelvic floor disorders at Rush-Presbyterian-St. Luke's Medical Center in Chicago.

Dr. Edward C. Wheeler of Carmel was named a fellow of the American College of Radiology.

Dr. J. Thomas Benson, an Indianapolis obstetrician and gynecologist, is editor of a recently published book titled *Female Pelvic Floor Disorders: Investigation and Management*, available from Norton Medical Books.

Dr. Tod C. Huntley of Head and Neck Surgery in Indianapolis spoke on "Intraoperative Radiation Therapy for Advanced or Recurrent Salivary Gland Malignancies" at the Third International Conference on Head and Neck Cancer in San Francisco.

Dr. Gregory T. Hardin, an Indianapolis orthopaedic surgeon, spoke on meniscal tear diagnosis, evaluation and treatment at the University of Indianapolis, Department of Physical Therapy.



Dr. Perkins

Dr. Stephen W. Perkins, an Indianapolis facial plastic and reconstructive surgeon, is serving a one-year term as secretary-elect of the American Academy of Facial Plastic and Reconstructive Surgeons (AAFPRS). During the AAFPRS annual meeting in Washington, D.C., he taught a master seminar on transconjunctival blepharoplasty and a course on chemical peel and participated in a panel discussion on transconjunctival blepharoplasty. Dr. Perkins, in conjunction with colleagues who previously studied at his plastic surgery center, presented two papers to the AAFPRS; topics of the papers were "Herpes Prophylaxis for Chemical Peel and Dermabrasion" and "The Use of Submentoplasty to Enhance Cervical Recontouring in Facelift Surgery." He was a panelist discussing "Photo Documentation for Facial Plastic Surgery" and "Lighting Considerations in Computer Imaging" at the fall meeting of the AAFPRS in Birmingham, Ala. Dr. Perkins spoke on rhinoplasty, blepharoplasty, and forehead and brow lifts at the annual meeting of the Mexican Society of Facial Plastic Surgeons in Acapulco.

Drs. William R. Nunery, **Stephen W. Perkins** and **A. Michael Sadove** of Indianapolis

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

September
Alexander, C. Kurt, Muncie
Bitar, Jihad, Lafayette
Carroll, Mary E. Davis, Crown Point
Diaz, David R., Indianapolis
Feuer, Henry, Indianapolis
Fouts, John B., Fort Wayne
Glassley, Stephen H., Fort Wayne
Goyne, Cheryl, Valparaiso
Harper, Kimberly A. Young, Carmel
Hochstetler, Mark A., Fort Wayne
Hoog, John M., Fort Wayne
Hull, Joel I., Chesterton
Johnston, Philip E., Indianapolis
Keener, Gerald T., Indianapolis
Kho, James B., Terre Haute
Knuth, Keith R., Indianapolis
Kolettis, John G., Merrillville
Luerssen, Thomas G., Indianapolis
Ng, Anastacio C., Indianapolis
Nowak, Gregory S., Elkhart
Poor, Maria C., Indianapolis
Roach, Eugene G., Anderson
Rold, James F., Evansville
Romain, Louis F., Fort Wayne
Samaddar, Prasoon K., Bedford
Sandock, Mark S., South Bend
Schultz, Karl W., Granger
Seitz, Katrina A., Indianapolis
Sharvelle, Derek J., Lafayette
Von Stein, G. Alan, Bargersville
Yolles, Elliott A., Indianapolis
Zieg, R. Daniel, Indianapolis

October
Armbuster, Thomas G., Fort Wayne
Bingle, Glenn J., Indianapolis
Feliciano, Elpidio G., Clinton
Ferree, Mary M., Indianapolis
Fitko, James, Valparaiso
Guha, Durga D., Clinton
Habegger, Elmer D., Indianapolis
Hansell, Richard S., Indianapolis
Hutter, George E., Fishers
Johnson, Robert D., Madison
Lustig, William F., Columbus
Micon, Larry T., Indianapolis
Nasr, Suhayl J., Michigan City
O'Brien, Francis E., Rensselaer
Pitts, Neal C., Bluffton
Prasad, Mridula R., Merrillville
Rayes, Hassan, Princeton
Rehn, Charles E., Brownsburg
Riley, Henry S., Madison
Sawlani, Tulsi C., Valparaiso
Storm, Richard M., Indianapolis
Waksman, Alberto, Bluffton

people

were faculty members at a facial plastic surgery seminar sponsored by the Indiana University School of Medicine. Dr. Nunery spoke on reconstruction of the paralytic eyelid and eyelid reconstruction. Dr. Perkins led a discussion on scar revision and was on a panel about facial trauma and nasal defects. Dr. Sadove presented seminars on scalp reconstruction and facial reanimation and participated in panels on traumatic facial and nasal defects, midfacial defects and facial paralysis. During the fall meeting of the American Society of Ophthalmic Plastic and Reconstructive Surgery, Dr. Nunery was a panelist for a discussion of "Hydroxyapatite Orbital Implant" and discussed a paper on "Smoking as a Cause of Ophthalmic Graves' Disease, coauthored with colleague **Dr. Ronald T. Martin**. At the annual meeting of the American Academy of Ophthalmology, Dr. Nunery participated in panel discussions on orbital fractures and eyelid surgery.

Activities and accomplishments of physicians from Orthopaedics Indianapolis include the following: **Dr. F. Robert Brueckmann** spoke on femur fractures at the American Fracture Association Conference in Anchorage, Alaska. **Dr. William O. Irvine** wrote an article on "Feet Under Force: Treating Sprains and Strains" that appeared in *The Physician & Sports Medicine*. **Dr. Sanford S. Kunkel** spoke on ACL reconstruction at the AAOS meeting in Palm Springs, Calif. **Dr. Andrew J. Vicar** spoke on common office hand problems at Dukes Memorial Hospital in Peru.

Dr. George E. Hutter of Fishers was named a fellow of the American Academy of Family Physicians.

Dr. Daniel M. Overcash has opened an internal medicine practice at 3500 Lafayette Road in Indianapolis.

Dr. Max Mertz of Goshen won the drawing for free participation in the ISMA's Practice Assessment/Quality Improvement (PA/QI) program. The drawing was held at ISMA's annual meeting last October. PA/QI is a new risk management program sponsored by the ISMA and Physicians Insurance Company of Indiana.

Dr. Richard S. Troiano, a specialist in hand, reconstructive and plastic surgery in Indianapolis, has successfully completed the examination for certification of added qualification in surgery of the hand.

Newly elected members of the Methodist Health Foundation Board of Directors in Indianapolis are **Drs. Richard F. Graffis**, **Bev T. Maxam**, **Eugene Van Hove** and **Donald L. Wilson**.

Dr. Donn R. Chatham of New Albany was elected to the American Board of Facial Plastic and Reconstructive Surgery Board of Directors.

Dr. Donald J. Hooker has retired after 30 years as a family physician in Ligonier.

Dr. Frank Hare, a Madison internist, was honored by King's Daughters' Hospital, which dedicated the intensive care unit in his name; he recently retired after 38 years of service in the Madison area.

Dr. Michael A. Hinshaw, a Richmond general surgeon, received the 1992 Paul S. Rhoads M.D. Humanity in Medicine Award from Reid Hospital in Richmond.

Dr. Randall C. Blake, an Anderson urological surgeon, was elected president of the Madison County board of directors of the American Cancer Society.

Dr. Stephen J. Jay, senior vice president for academic/medical affairs at Methodist Hospital in Indianapolis, received the Tony and Mary Hulman Health Achievement Award from the Indiana Public Health Foundation.

Three Richmond doctors recently retired; they are **Dr. James R. Daggy**, family physician for 40 years; **Dr. John H. Mader**, internist for 44 years; and **Dr. Morris C. Snyder**, family physician for 47 years.

Dr. R. Buckland Thomas was named medical director for the behavioral sciences department at St. Mary's Medical Center in Evansville.

Dr. Robert C. Stone, a Ligonier family physician, was honored for his 33 years of public health service by the Noble County Health Board; he served as health officer for 15 of those years.

Dr. Warren L. Bergwall, a Muncie family physician, officially retired after 40 years in private practice; he continues as Ball Memorial Hospital's hospice program director and a hospital staff member.

Dr. Edward R. Bush, an Anderson general practitioner, was named St. John's Children's Clinic Volunteer of the Year.

Dr. Alfred A. Serritella, a LaPorte gastroenterologist, was one of six physicians honored by the Greater Chicago Chapter of the Crohn's and Colitis Foundation of America; he helped found the chapter.

Dr. Patricia Harper, an Indianapolis radiologist, was elected president of the Indiana division of the American Cancer Society.

Dr. Thomas G. Hamilton, a

Columbia City family physician, retired after 42 years in practice.

Dr. Samuel M. Wentworth, a Danville pediatrician, received the Sagamore of the Wabash Award from Gov. Evan Bayh; he specializes in diabetes in his Danville office and satellite offices in Terre Haute and Indianapolis.

Dr. Thomas K. Browne, a pulmonary specialist, is the new president of the medical staff at Deaconess Hospital in Evansville. Dr. James A. Rang, an orthopaedic surgeon, is president-elect.

Dr. Frank W. Peyton, a Lafayette obstetrician and gynecologist, retired after 55 years in practice; he founded the Woman's Clinic in Lafayette and delivered more than 11,000 babies.

Dr. Robert H. Rang, a Washington, Ind., surgeon, has retired; he opened his practice in Daviess County in 1949.

Dr. Robert A. Craig has retired after 46 years as a Syracuse family physician. ❑

New ISMA members

Andre K. Artis, M.D., Gary, internal medicine.

Thomas R. Baeker, M.D., Louisville, Ky., hematology.

Diane E. Begley, M.D., West Lafayette, family practice.

Michael Berkowitz, M.D., Indianapolis, physical medicine and rehabilitation.

William C. Biehl III, M.D., Michigan City, orthopaedic surgery.

Lisa N. Booth, M.D., Fort Wayne, family practice.

Irwin F. Borowski, M.D., Cayuga, obstetrics and gynecology.

Michelle O. Boyer, M.D., Brownsburg, family practice.

Gregory W. Brown, M.D., Columbus, anatomic/clinical pathology.

Steven L. Cauble, M.D., Goshen, psychiatry.

Daniel R. Cecil, M.D., Fishers, emergency medicine.

Ronald C. Childs, M.D., Gary, orthopaedic surgery.

Min K. Choi, M.D., Indianapolis, internal medicine.

Brian E. Coleman, M.D., Gary, orthopaedic surgery.

Neal E. Coleman, M.D., Muncie, anesthesiology.

Cheryl A. Crawford, M.D., Dale, family practice.

Daniel J. Cummiskey, M.D., Fort Wayne, orthopaedic surgery.

Floy E. Detwiler, M.D., Hagerstown, family practice.

John M. Diveris, M.D., Gary, orthopaedic surgery.

Eduard Dvorak, M.D., Vincennes, radiation oncology.

David K. Evans, M.D., Indianapolis, cardiovascular surgery.

Thomas J. Failinger, M.D., Greenfield, cardiovascular diseases.

Joseph J. Fata, M.D., Indianapolis, plastic surgery.

John A. Fayyad, M.D., Michigan City, child psychiatry.

Rebecca E. Galante, M.D., Dyer, internal medicine.

Ruta P. Gandhi, M.D., Mishawaka, allergy and immunology.

Kiran Gojnur, M.D., Chicago, emergency medicine.

Mythili Gurram, M.D., Evansville, internal medicine.

Sudheer Gurrma, M.D., Evansville, internal medicine.

Robert W. Gutekunst, M.D., Munster, anatomic/clinical pathology.

Richard A. Hahn, M.D., Indianapolis, cardiovascular diseases.

Jeffrey L. Harris, M.D., Fort Wayne, family practice.

Kevin K. Hart, M.D., Muncie, internal medicine.

Douglas J. Hatler, M.D., Evansville, family practice.

June D. Hillelson, D.O., Indianapolis, internal medicine.

Olaf B. Johansen, M.D., Mooresville, colon and rectal surgery.

Ian Johnson, M.D., Michigan City, obstetrics and gynecology.

John G. Jones, M.D., New Palestine, emergency medicine.

Sai R. Karlapudi, M.D., Muncie, allergy and immunology.

James H. Kim, M.D., Oak Brook, Ill., anesthesiology.

Thomas E. Klootwyk, M.D., Indianapolis, orthopaedic surgery.

Kiran U. Koka, M.D., Kokomo, psychiatry.

Jeff B. Latham, M.D., Indianapolis, anesthesiology.

Abdul G. Loya, M.D., Naperville, Ill., emergency medicine.

Debra J. Madura, M.D., Lafayette, obstetrics and gynecology.

Jeannine M. McMahon, D.O., Crown Point, obstetrics and gynecology.

Margaret R. Miser, M.D., Indianapolis, obstetrics and gynecology.

Kevin D. Neese, M.D., Batesville, internal medicine.

Rosita S. Ngu, M.D., Munster, anatomic/clinical pathology.

Gregory P. Nicholson, M.D., Indianapolis, orthopaedic surgery.

Jose Pabon, M.D., Munster, anatomic/clinical pathology.

Stephen C. Pappas, M.D., Indianapolis, gastroenterology.

Stephen O. Pastan, M.D., Bloomington, internal medicine.

Jancy G. Pottanat, M.D., Washington, family practice.

Kevin A. Rahn, M.D., Fort

Wayne, orthopaedic surgery.

Mark A. Richter, M.D., South Bend, internal medicine.

L. Ralph Rogers, M.D., Evansville, obstetrics and gynecology.

Edward J. Ryan, M.D., New Albany, neurology.

Joseph G. Samyn, M.D., Crown Point, internal medicine.

Luis A. Santos-Cruz, M.D., Indianapolis, gastroenterology.

Rick C. Sasso, M.D., Carmel, orthopaedic surgery.

David M. Scheidler, M.D., Indianapolis, urological surgery.

Bruce W. Schneider, M.D., Evansville, gastroenterology.

Mark P. Schopper, M.D., Brownsburg, family practice.

Mary Beth Schueth, M.D., Carmel, internal medicine.

Roya V. Seysan-Sabour, M.D., Richmond, family practice.

Dinesh M. Shah, M.D., Highland, internal medicine.

Ketan K. Sheth, M.D., Lafayette, pediatrics, allergy.

Curtis E. Shinabarger, M.D., Evansville, otolaryngology.

Thomas J. Singel II, D.O., Chicago, emergency medicine.

Pradeeep K. Singh, M.D., Bloomington, internal medicine.

Robert C. Smith Jr., M.D., Fort Wayne, family practice.

Thomas A. Soisson, M.D., South Bend, pediatrics.

Franklin L. Spain Jr., M.D., Lafayette, general surgery.

Lucia M. Spears, M.D., Indianapolis, diagnostic radiology.

Donald E. Stork, D.O., Munster, family practice.

Leslie F. Stork, M.D., Munster, family practice.

Stephen J. Strycker, M.D., South Bend, anesthesiology.

Thomas J. Sweeney, D.O., South Bend, internal medicine.

Hassan Tavakkoli, D.O., Indianapolis, ophthalmology.

John R. Thompson, M.D., Nashville, child psychiatry.

Richard F. Thompson Jr., M.D., Fort Wayne, psychiatry.

Donald R. Troyer, M.D., South Bend, family practice.

Luis L. Villarruel, M.D., Seymour, family practice.

Denise C. Weaver, M.D., Munster, infectious diseases.

Edward A. White, D.O., Evansville, family practice.

Kurt A. Wiese, M.D., Munster, obstetrics and gynecology.

Jeffrey L. Witt, M.D., Richmond, family practice.

James C. Yelton, M.D., Evansville, orthopaedic surgery.

Residents

Glenn A. Loomis, M.D., Indianapolis, family practice.

Erik B. Throop, M.D., Indianapolis, general surgery. ❑

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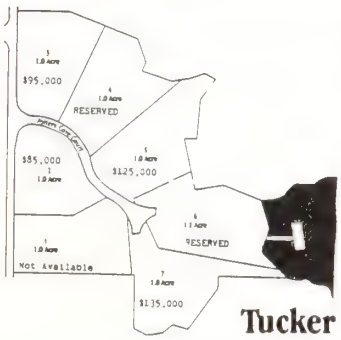
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plines with interest in outpatient medicine. Full-time opportunities only. Contact Jim Gardner, M.D., Director, Corporate Development, Emergency Care Physicians, 640 S. Walker St., Suite A, Bloomington, IN 47403, (812) 333-2731.

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WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY, Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS, Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin, the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin.* See WARNINGS, Skeletal Muscle.

Antipyrine. Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine. The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* (1 hour prior to PRAVACHOL), *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, or cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*, a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter^2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS, **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated, adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug.

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma, anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS, **Skeletal Muscle** and PRECAUTIONS, **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

(J4-422A)

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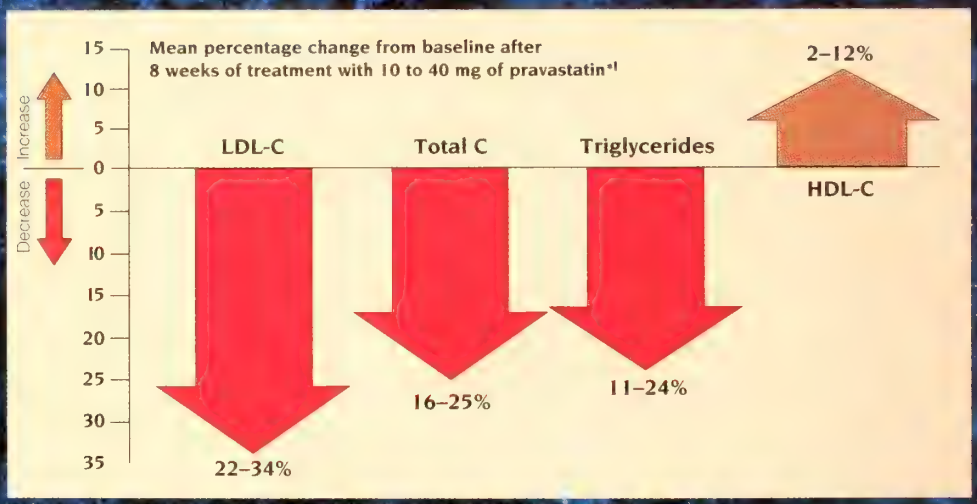
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Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

PRAVACHOL pravastatin sodium 20 mg tablets

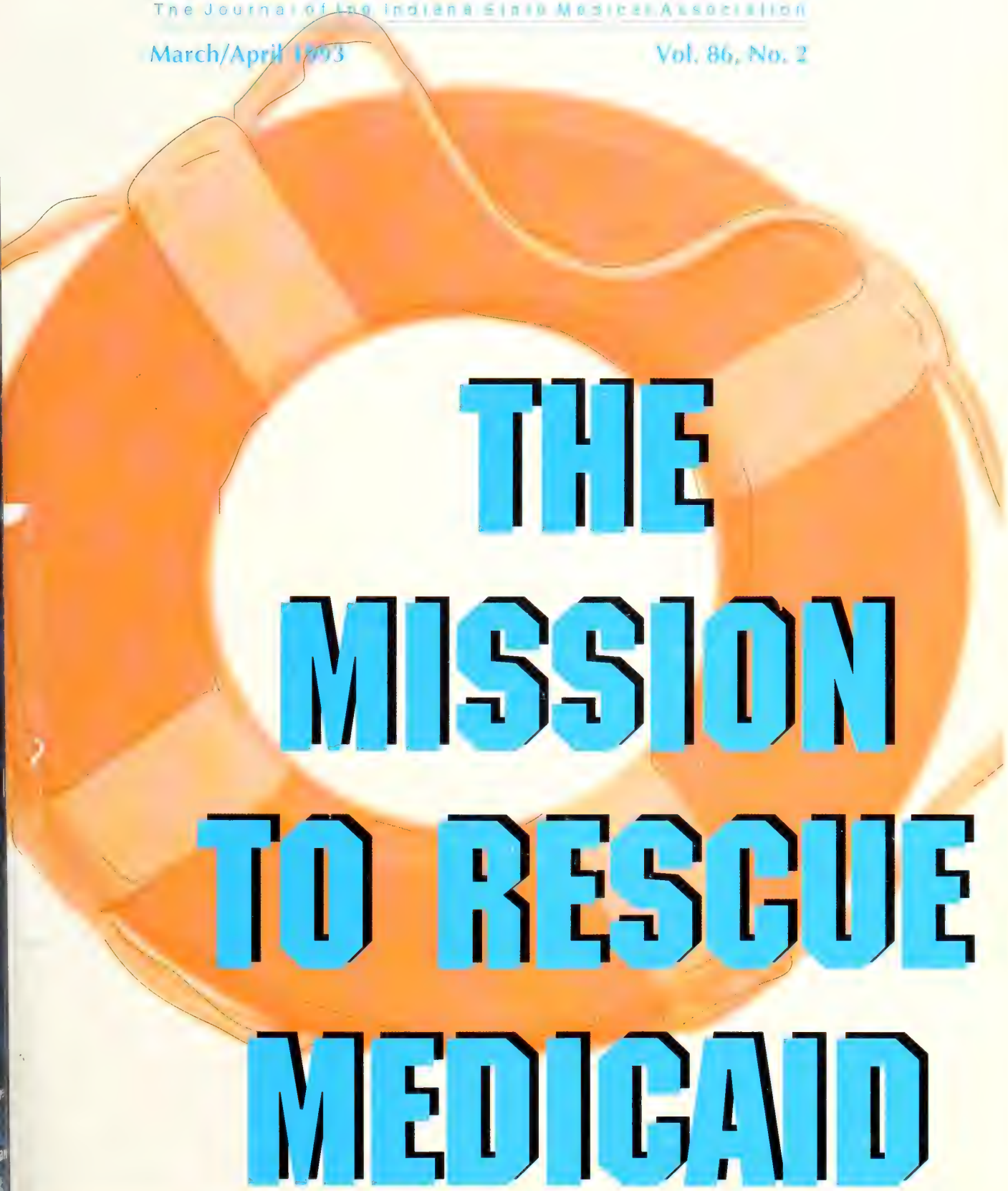
Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page

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INDIANA MEDICINE

The Journal of the Indiana State Medical Association

March/April 1993 Vol. 86, No. 2



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INDIANA MEDICINE

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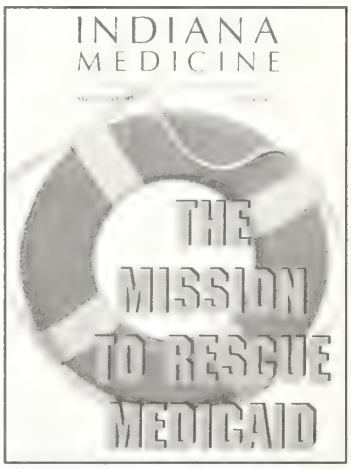
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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

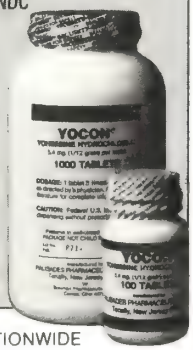
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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ISMA presents Medicaid proposal to Indiana legislature

The ISMA Medicaid proposal presented to the Indiana Senate Committee on Planning and Public Services would implement a case management system and provide a basic benefit package. The proposal would:

- Implement a case management system with co-payment.
- Reduce optional benefits and provide a basic benefit package.
- Establish a funded position for investigating Medicaid abuse and fraud to be under the auspices of the Indiana Medical Licensing Board.
- Increase the personal income tax and tax on cigarettes and alcohol.
- Eliminate scheduled physician payment increases.
- Implement the resource-based relative value scale for Medicaid.

The proposal was created by the ISMA Medicaid Task Force and refined by the ISMA Board of Trustees. Task force members are Timothy Brown, M.D., Crawfordsville; Steve Tharp, M.D., Frankfort; Susan Pyle, M.D., Union City; and Frank Johnson, M.D., Indianapolis.

ISMA seeking support for increase in state cigarette tax

In an effort to seek more support for an increase in the state cigarette tax, the Indiana State Medical Association participated in a news conference Feb. 18 with other groups that favor the hike. William H. Beeson, M.D., ISMA president, represented the ISMA, saying, "Tobacco use cost the United States $72 billion in health care and lost productivity in 1991. Our society can no longer pick up the tab for those who refuse to take the responsibility for their health by choosing to smoke.

"We must discourage tobacco use, particularly among teenagers. Making the purchase of tobacco illegal for anyone under age 18 was one step. Unfortunately, it has not worked. Twenty-four percent of high school seniors in Indiana smoke as compared to 19% nationally. The tragedy of this is if we can prevent teenagers from smoking by age 19, most never pick up the habit."

The tax increase is being supported by several legislators who attended the news conference, including Sen. Mike Gery, D-West Lafayette; Rep. Mark Kruzan, D-Bloomington; Sen. Marvin Riegsecker, R-Goshen; Sen. Vi Simpson, D-Bloomington; and Rep. Sheila Klinker, D-Lafayette. The plan would raise the tax from 15.5 cents to 33 cents.

The ISMA wants funds from the tax to be used for childhood immunizations and a tuition abatement program for medical students who agree to practice in a medically underserved area in Indiana. ❑

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letter to the editor

Editor's note: George C. Manning, M.D., Fort Wayne, sent the following letter to Louis Sullivan, M.D., late last year, when Sullivan was still serving as secretary of the Department of Health and Human Services.

Dear Dr. Sullivan:
As you know, at your direction each Medicare carrier has been directed to establish a physician advisory committee. This has been done in Indiana by Blue Cross/Blue Shield doing business as AdminaStar Federal, located in Indianapolis.

I do not believe that the composition of the committee is in accordance with your intentions. Of the 34 members, all appointed by BC/BS, 25 are from Indianapolis and its suburbs. The appointed chairperson of the committee is an employee of Blue Cross/Blue Shield.

The city of Fort Wayne, which is by far the second largest municipality in the state, has been allowed one member. Fort Wayne has 25% the population of Indianapolis, and Allen County, in which Fort Wayne is located, has approximately a third of the population of Marion County, in which Indianapolis is located. South Bend, which has slightly more than half the population of Fort Wayne, has been allocated two members. The remaining members are from scattered small semirural communities, with the exception of one from Anderson, a manufacturing city.

It should be pointed out that Fort Wayne serves as the medical center for northeast Indiana and parts of northwestern Ohio, even to the extent of having an approved organ transplant service.

It is my opinion that the composition of the physician advisory committee appointed by Blue Cross/Blue Shield in Indiana represents a "stacked deck" that is not in the least representative of the physicians in Indiana. I wonder if the Blues have set up the same sort of thing in other areas as well. May I respectfully suggest that your department investigate this inequity in Indiana and elsewhere and take whatever steps you deem appropriate to correct it.

George C. Manning, M.D.
Fort Wayne

Letters to the editor

INDIANA MEDICINE welcomes letters from readers. Please submit double-spaced, typed letters that are limited to 250 words and include your name and address. Letters may be edited for space, style and grammar.

Send your letters to George T. Lukemeyer, M.D., INDIANA MEDICINE, 322 Canal Walk, Indianapolis, IN 46202-3252. ❑

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editorial

Health care reform should begin with insurance industry

Michael O. Mellinger, M.D.
Chairman, ISMA Commission on Legislation

Health care reform. Everyone seems to agree something needs to be done. Nearly everyday we are bombarded by news of the "health care crisis." We don't have a health care crisis in this country – Somalia has a health care crisis. What we are dealing with is a health care financing crisis. Many factors, including exploding technology, have rendered the cost plus fee-for-service system unworkable in many situations. The cart is broken, and society is taking deadly aim at the horse. Yet, it is clearly not in the best interest of society to dismantle the private practice of medicine because the payment system has broken down.

Some would (and do) say that the time has come to replace both the cart and the horse and go to a government-administered single payer system of health care. However, without a large infusion of new capital to cover administrative costs, any centralized system will decrease rather than improve access to care. It seems unlikely that a society intent on holding the line on taxes for middle-income workers will be anxious to bite the fiscal bullet that a single payer system would require.

Traditionally doctors and hospitals have been the insurance of last resort. People in need of care have not been turned away because of an inability to pay. Needed services have been provided regardless of financial status. Providers have been able to absorb expenses for uncompensated care although it must be recognized that those who could afford to pay bore the brunt of this burden of uncompensated care.

Today the system is breaking down. From coast to coast, states are grappling with health care reform and, not surprisingly, insurance reform heads the list. In many regions of the country upwards of 25% of Americans find themselves unable to afford to buy health care insurance. Forty percent of uninsured are self-employed small business people, their employees and dependents. The old equation of the few needing help from the many is in danger of being reversed.

Underwriting practices by the private insurance industry are a major cause of the developing imbalance between the insured and the uninsured. Private health insurance companies hasten to insure the young and healthy and, unfortunately, are just as quick to drop those who develop conditions that are apt to require the protection that insurance companies supposedly sell.

The private health insurance industry is committing gradual suicide by placing the emphasis on avoiding risk rather than the traditional goal of spreading it. The giants in the industry are able to mount marketing efforts to insure large numbers of young and basically healthy workers. Smaller insurance companies are then left with a dilemma. They can either take all applicants, a group unfairly weighted toward high risk by current underwriting practices, or they can emulate their competitors by also refusing to insure those at higher risk. In the highly competitive world of insurance, it is not difficult to predict this decision. Until the health insurance industry is prohibited from "cherry picking" the healthy young people, while excluding the high-risk patients, the problem of access to health care can only get worse.

Immediate and long-term insurance reforms are needed. Reforms should include some special considerations for small business. Indiana's efforts have thus far been ineffective in this area. Community-based rating as opposed to experience-based rating would improve access to health insurance for many small business employees.

A basic benefits package needs to be defined. For example, we all agree that emergency treatment for a heart attack or acute appendicitis should be a basic benefit. On the other hand, certain types of treatment without functional value ought not to be on the list. A basic benefits package should be uniform among insurers so that consumers can compare and determine which package meets their needs.

Health insurance should be portable between jobs. Fifty percent of the uninsured in Indiana are uninsured for four months or less. Compared to other proposals, a four-month tail coverage for employees terminating employment would be relatively inexpensive and immediately reduce Indiana's uninsured by half.

Guaranteed renewability at a reasonable price for small employer group health insurance also is needed. Reforms adopted in 1992 for small employer group health insurance have loopholes. Instances of insurance companies threatening to cancel an entire company's benefits when one employee becomes ill or injured still occur.

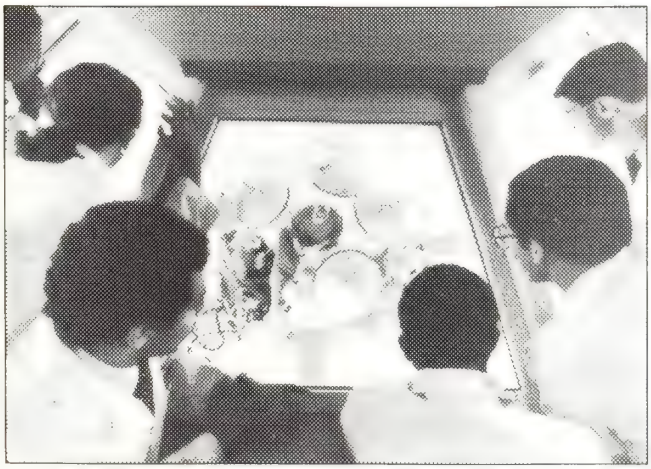
Simplified and uniform claims procedures and insurance forms would reduce the hassle factor for both patients and physicians.

Exclusions for pre-existing illnesses must be addressed. It is unfair to exclude an individual for life from access to health care insurance because of illness or injury. Creating a reasonable waiting period would be a workable approach.

Finally, let's look at the cost of operating the Indiana Comprehensive Health Insurance Association (ICHIA), the state-run risk pool. The pool is expensive, in part, because of the cost of administering a separate bureaucratic infrastructure. We need to get patients out of the risk pool and back into mainstream insurance.

A few relatively simple reforms for the health insurance industry could greatly reduce Indiana's uninsured population and do it at a fraction of the cost of other sweeping proposals that call for an entirely new layer of administrative bureaucracy. We do not need to dismantle our current health care system. ❑

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editorial

Just say 'no' to 'trips'

George Lukemeyer, M.D.
INDIANA MEDICINE **Editorial Board Chairman**

After three years of Indiana's Multiple Copy Prescription program, we're still not convinced that "trips" has fulfilled what it promised. The Indiana State Medical Association continues to be concerned that the triplicate prescription program adversely affects patient care because it prevents physicians from aggressively treating pain.

While proponents argue that "trips" has served as a deterrent to drug diversion, ISMA believes that it has diverted abuse into Schedule III drugs. Nor is it resulting in the convictions envisioned.

A better solution to drug diversion is a program proposed in SB 504 in which all prescriptions are monitored and physicians are not required to use a special prescribing pad.

The Electronic Data Transfer system, already in operation in Oklahoma and embodied in SB 504, provides a way to track prescription drug abuse and diversion more efficiently, more accurately and with less hassles for physicians.

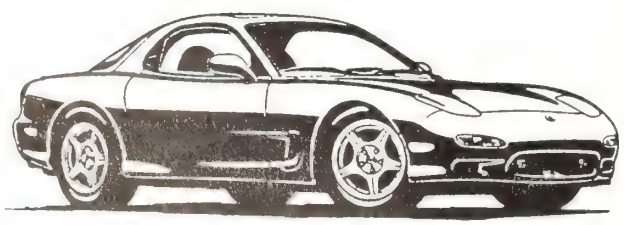
Here is the way the system works: a physician writes a prescription. When the patient presents the prescription to the pharmacist, the pharmacist enters the information into the computer, which is on-line with the state. For larger pharmacies, the information can be down-loaded to the state on a daily basis. Lower volume pharmacies would be required to electronically transfer information less frequently. Such a program would alleviate the 45-day lag time and eliminate the "second copy" paper transfer common to "trips."

Since all prescriptions could be entered into the system, SB 504 would allow the state, through the Controlled Substance Advisory Committee, to determine, based on data collected, which drugs should be monitored.

The Indiana General Assembly should pass SB 504. ❑

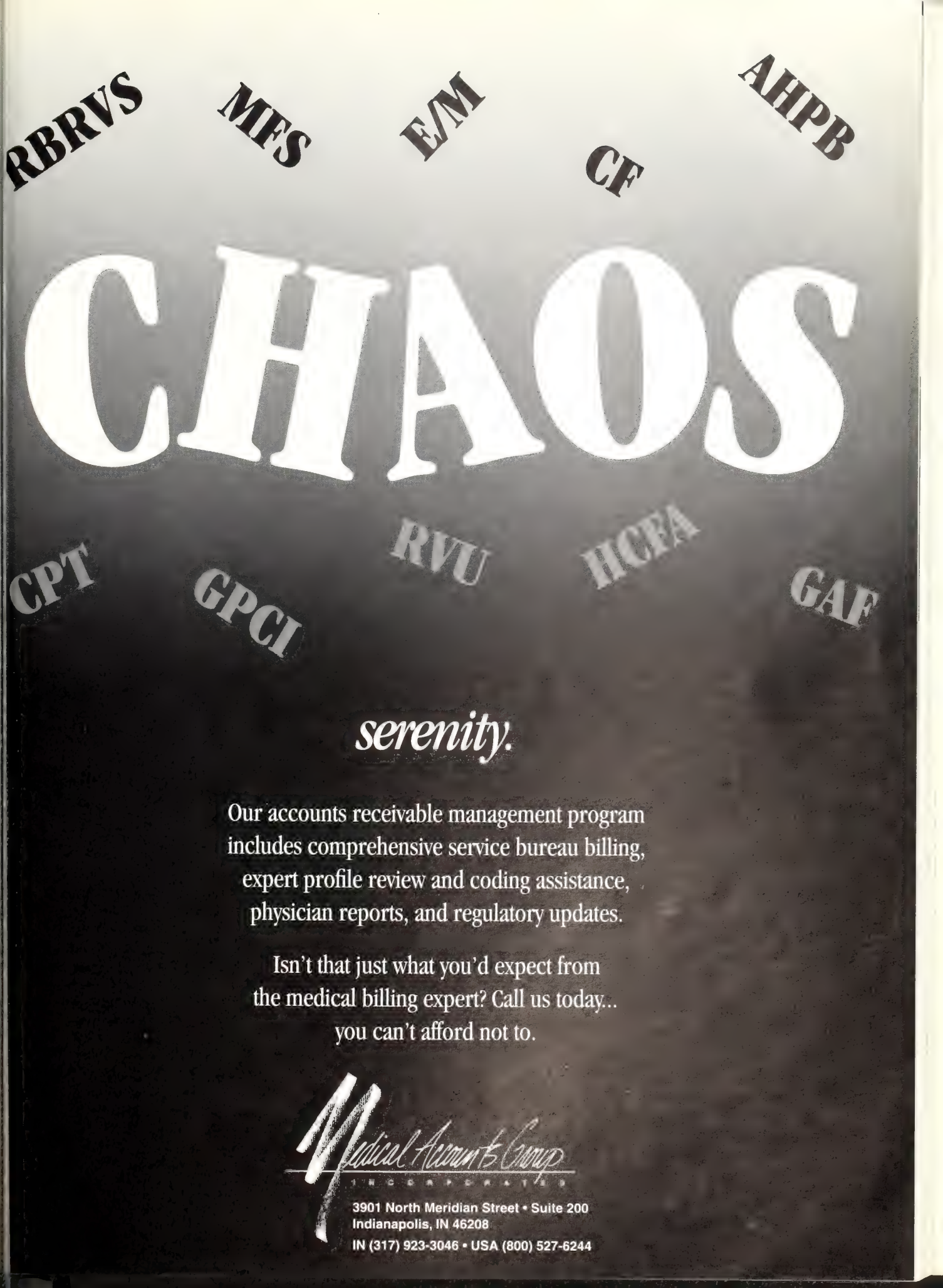
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commentary

Reversing the decline and fall of the general internist

Robert D. Robinson, M.D.
Indianapolis

The general internist in 1960 perceived himself to be at the apex of the medical profession. He was respectfully referred to as consultant, diagnostician, doctor's doctor. His was the last word in difficult medical situations.

Contrast this to today's young internist, who may furtively refer to himself as "just a general internist." He is now encouraged to prepare and perform as a gatekeeper, triage officer, lifestyle counselor, psychosocial therapist and computer operator. He has become a foot soldier in the trenches of medicine whose central function sometimes appears to be diversion of the worried well and referral of the others to an appropriate subspecialist. Some would consider this a fall from grace.

This slippage on the ladder of medical prestige has occurred because the rules of the medical game have been changed. The **clinical diagnosis**, long the stock-in-trade of the internist, has been replaced as the gold standard of medicine by **diagnostic certainty technologically confirmed**. The clinical diagnosis, after all, was really an educated guess, dependent for its value on the experience, compulsiveness, examination skills and intuition of the guessor. Diagnostic certainty on the other hand presupposes a photo, tracing or microscopic slide, and the ability to deliver such visual confirmation has been snatched from the general internist and locked away by his subspecialist brethren. Denied the privilege of offering his patient a final answer, that is, a diagnosis rather than a guess, the generalist feels deprived of that patient respect and confidence that had previously been his greatest personal reward and was the foundation of ongoing patient care.

Left only to refer, console and follow the management instructions of the consultant subspecialist, the general internist has begun to perceive himself a second-class medical citizen. While patients and society may indeed find worth in the general internist's hand-holding role as long as it comes cheaply, insurance companies and other reimbursing agencies have been brutally honest in making their own value assessments. Is it really any mystery why fewer young physicians now become generalists?

General internal medicine is rapidly becoming the prison of those not quick enough to escape to subspecial training, emergency rooms, academic or administrative sinecures, "doc-in-the-boxes" or occupational health. The subspecialist and his progeny, the subsubspecialist, on the other hand, thrive and proliferate. These subspecialty careers are competitively filled from the best generalists but demand less intellectual diversity and interpersonal flexibility as the subspecialization becomes increasingly focused. This "upward mobility" results in a perverse academic Peter Principle wherein the most intellectually and interpersonally gifted house officers are progressively promoted into "more advanced" specialties. This phenomenon creates a progressive mismatch between challenge and capability at both ends of the generalist-specialist spectrum.

Meanwhile, hospitals in smaller communities are threatened with closure because they do not have the patient volume to support medical subspecialists, and the generalists on their staff do not have the technological skills necessary to take care of sicker patients and make confirmed diagnoses. Since only the sickest patients qualify for hospitalization these days, the result is empty small rural hospitals.

Some say the general internist as we knew him 35 years ago is obsolete, and family practice and general medicine should merge to produce a generic primary care physician who will be content to perform screening for the steadily increasing number of subspecialists. In time, oversupply might even force these subspecialists into smaller communities where the big city model could be replicated. Or perhaps small hospitals should be closed and the resources invested in transportation to tertiary centers, many of which would welcome such an influx of referrals.

But for those who believe that a scientifically based and widely competent personal physician is a blessing for his or her patients and who believe that a good hospital nearby is what most rural patients want, a third option deserves consideration to salvage the disappearing general internist.

First however, certain current myths of medical practice need to be debunked, and the basic structure of internal medicine training should be changed.

Myth 1

A medical subspecialist is a generalist first and a subspecialist second. While this concept sounds reasonable and is a natural outgrowth of the way clinical training has evolved, it is quite con-

trary to the practice habits of most subspecialists. In academic centers, subspecialists teach, staff and provide patient care almost exclusively in their chosen subspecial fields, and in community practice, they often go to great lengths to avoid any hint of general competence, interest or responsibility. "I'm a specialist and will rule out or manage disease in my area. Someone else can have the messy rest."

Quality has been invoked to justify this attitude, but such quality concerns may obscure other reasons. These reasons may include a desire to keep the option of noninvolvement open with patients who are problematic or difficult to deal with, more time for technical activities, respect for turf borders with other subspecialists and a misconception of the desires of referring physicians.

The goal of many subspecialists seems to be to delegate full evaluation and ongoing patient care to someone else, that is, nurses, physician assistants, house staff, hired moonlighting medical students and residents or referring generalists.

Myth 2

Because repetition begets increasing competence, instrumentation must, for quality and safety reasons, be reserved for the subspecialist. This half-truth seems self-evident. But if a learning curve does exist with most procedures, it must flatten at some point. Repetition does indeed make for facility, but it may also make for mindlessness and over-utilization. Generalists throughout the United States are performing certain endoscopies, biopsies, exercise tests and other procedures safely and effectively. The training and experience adequate for safety and competence in the performance of most procedures have been outlined by the appropriate subspecialty societies, and providing such experience for the more common invasive procedures does not seem beyond the capabilities of most internal medicine training programs.

But even if the generalist in search of enhanced diagnostic capabilities slips by myth 2, he runs into credential committees made up of section chairman (subspecialists) and finds invoked:

Myth 3

It isn't the procedure itself that defines the subspecialist but rather the knowledge and experience to use it appropriately. Again, the facts differ from the perception. Most subspecialists see a narrow variety of repetitive problems for which they rush through the cognitive rituals to their inevitable diagnostic technology: "Twenty-two-year-old college student with upper gastrointestinal bleeding. Patient seen. Will scope in morning." To a man with a hammer everything may look like a nail, and not infrequently, the subspecialist's tunnel vision obscures rather than elucidates the correct diagnosis.

The reality is that generalists frequently refer patients to subspecialists because they need access to their technology rather than to their their cognitive skills. In addition, referral for one procedure often leads to others, as the subspecialist, after unleashing his own arsenal of technology, "just to be sure" may pass the patient on to another subspecialist. Most general internists can manage most problems once diagnosis is confirmed, and most internists could safely use the tools required to make most confirmed diagnoses if properly trained and permitted to do so.

The following prescription is offered as a remedy for the "sick man" of medicine, the general internist:

1. Medical subspecialists, whose future career will center around technology, should take only one year of general medicine training before they enter their fellowships. Neurologists do this, and the breadth of their clinical duties is broader than that of many medical subspecialists. If subspecialty residency review committees really believe breadth of experience is important, there is ample opportunity for more general experience in the progressively elongating training tracts now required. With such a more limited general background, the cardiologist could more reasonably plead ignorance when asked to perform rectal, pelvic or breast exams. Likewise, the gastroenterologist more legitimately need not worry himself concerning the cause of a patient's chest pain once he had eliminated esophageal disease. Such training would be not too dissimilar from the "short track" double board programs of the 1950s and 1960s taken by many of those now in control of academic internal medicine training and certification.

2. A general internist should be trained for four or more years, and his procedural skills would include endotracheal intubation and ventilator management, central line insertion and management, upper gastrointestinal and nasopharyngeal endoscopy, therapeutic bronchoscopy, colonoscopy, treadmill exercise testing, bone marrow aspiration

and perhaps pleural and liver biopsy, peripheral doppler ultrasound, pacemaker insertion and transthoracic echocardiography.

These procedural capabilities would be refreshing and challenging alternatives to the cardiopulmonary resuscitation, arterial sticks and venipuncture, lumbar puncture, thoracentesis, paracentesis, pelvic exam, Pap smear, sigmoidoscopy and urinalysis now offered as the procedural envelope suggested for internists by the American Board of Internal Medicine (ABIM). As a matter of fact, most of the ABIM requirements normally have been accomplished before graduation from medical school. Even with the common and repetitive diagnostic procedures in the hands of generalists, there would remain adequate complex procedures and challenging diagnostic and therapeutic questions to keep a reasonable number of specialists busy and interested.

3. Those medical subspecialists who frequently perform generalist functions, such as endocrinologists, rheumatologists, neurologists and nephrologists, would be required to have two years of general medicine before subspecialization.

The actual use by the generalist of these procedural skills would depend on geographic location, evolution of local patterns of practice and the view of hospital credentials committees, of course, but the training would not be wasted, as it would at the very least enhance the generalist's interaction with and use of subspecial consultants. Our present system already trains many physicians in skills they do not use.

The net result of such training would be empowerment of the generalists to safely market **diagnostic certainty technologically confirmed** in many cases in which now they can only refer. It would allow them to intelligently refer to the subspecialist those complex problems and diagnoses actually needing such expertise. And lastly, general training would no longer be wasted on those who neither use nor want it.

These suggested changes in training and credentialing, to which might be added a general down scaling of the reimbursement level for procedures, are designed to accomplish the following:

1. General internists could make an adequate income.

2. General internists could once again make state-of-the-art diagnoses in most situations, resulting in improved morale.

3. Patients would have many procedures performed by the physicians who know them and their problems.

4. Smaller hospitals might keep their doors open.

5. Care would become more efficient and satisfying for the patient.

6. The escalation of health care costs might be slowed.

7. Health plans requiring case managers with wide capabilities would have an increasing pool from which to choose.

8. General internal medicine might once again attract the cream of the crop from medical schools.

The decline in the prestige and attractiveness of general internal medicine as a career for young physicians will not be reversed by raising the pass mark on the American board test, limiting work hours and patient loads in residency or downsizing the availability of internal medicine training programs.

Internal medicine will be attractive only when its practitioners find satisfaction in their work and return to their earlier role of diagnosing and caring for the sick, in addition to the worried well. ❑

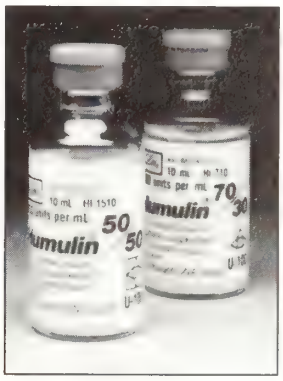
Dr. Robinson is chairman of the Department of Medicine and director of medical education at St. Vincent Hospital in Indianapolis.



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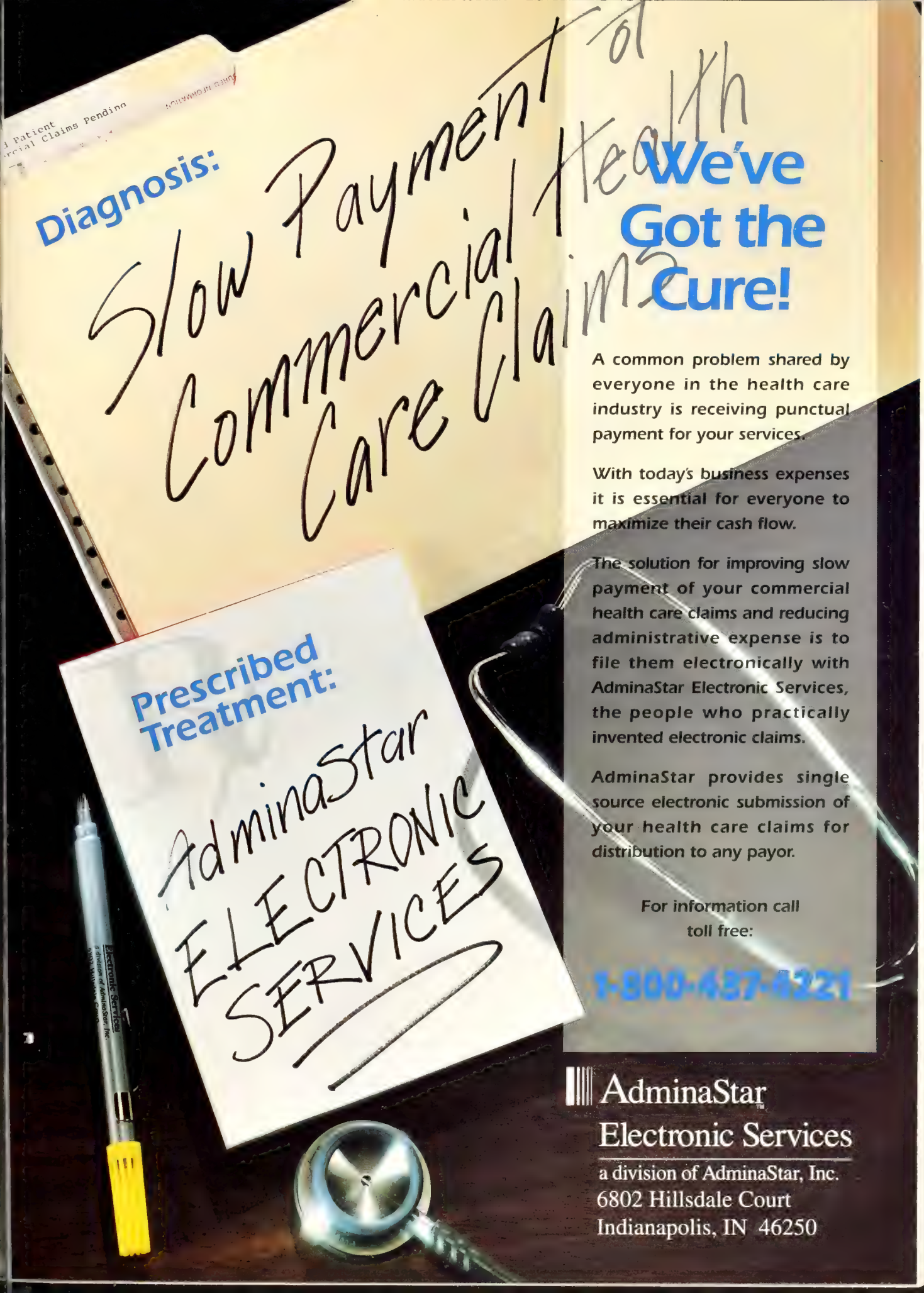
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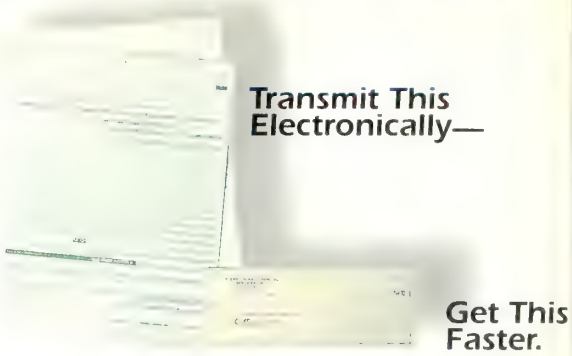
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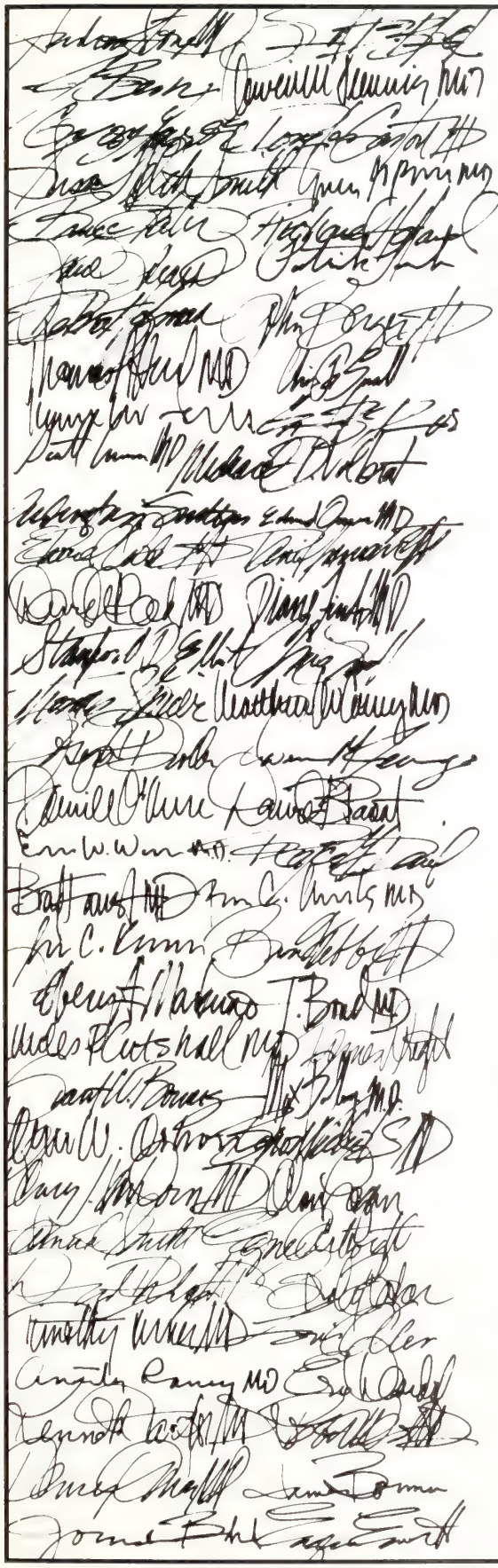
FEATURE	BENEFITS
Completely automates your claim process even when payor is not electronic	Eliminates printing, stuffing, and mailing paper claims
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Medicare, Blue Cross and Blue Shield, Champus & Key Health claims transmitted at no charge	Reduces claim cost

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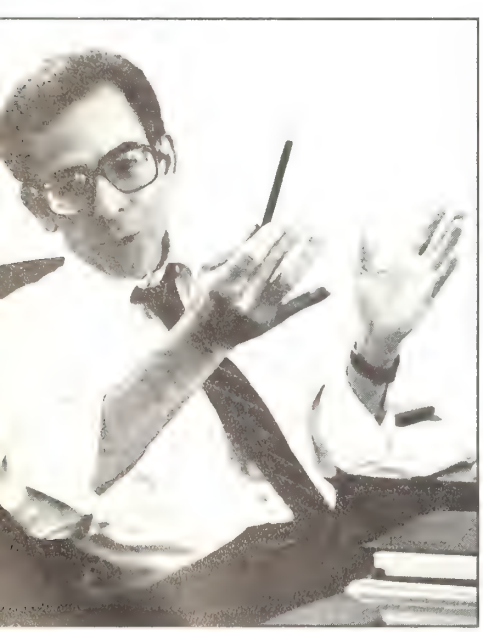
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Medicaid rescue

Bob Carlson
Indianapolis



Medicaid is by far the biggest component of Indiana's health care budget, which Gov. Evan Bayh has likened to an 800-pound gorilla that needs to be caged. This fiscal year alone, Indiana's Medicaid bill is expected to total $965 million, which is $170 million more than was estimated.

Indiana Medicaid expenditures have been increasing at a rate of nearly 20% a year for the last four years, while state revenues have been growing 3% to 4% annually. The increase alone in the state's Medicaid spending for the next two fiscal years is projected at $938 million, $135 million more than the revenue growth projected for the same two years. The governor has made Medicaid cuts an absolute prerequisite for more education funding and for holding the line on taxes.

One reason for the explosive increase in Medicaid costs is the recession in 1991 and 1992. More Hoosiers were forced to rely on Medicaid and, at the same time, state revenues declined by $1.2 billion. In addition, there have been federally mandated Medicaid increases, major fee increases in several provider categories and nationwide health care cost inflation of 8%, versus 3.2% for all consumer prices.

Compared to other states, Indiana also pays higher Medicaid provider fees and covers 28 of 31 optional services not mandated by federal Medicaid rules. Only three states cover more. According to James Verdier, Indiana's assistant secretary for Medicaid policy and planning, reducing these services is one option that is being considered, along with a variety of others.

In this conversation with INDIANA MEDICINE, Verdier makes it clear that there are very few ideas for cutting or offsetting Medicaid costs that are not on the table. He addresses some of these strategies, including provider taxes, also called "sick taxes," "sin" taxes, primary care case management, Medicaid reimbursement cuts and co-payments. He also passes along news about a new Medicaid claims processing system.

Verdier advanced to his current post from that of deputy commissioner, Medicaid and Administration, in July 1991. He previosly served as deputy director in the Michigan Department of Management and Budget; lecturer in public policy at the Kennedy School of Government, Harvard University; assistant director for tax analysis, Congressional Budget Office; and adjunct professor, Georgetown University Law Center.

He graduated *summa cum laude* from Dartmouth College, attended The Queens College, Oxford University, and holds a J.D. degree from Harvard Law School.

INDIANA MEDICINE: **Can you give us a brief overview of the Medicaid program, when it was enacted and what the arrangement is between states and the federal government and specifically what it is in Indiana?**

Verdier: The Medicaid program was enacted at the federal level in 1965. Indiana was one of the last states to set up a state Medicaid program under that authority. We set ours up in 1970, and it essentially looked the same way then

effort to be 'painful'

that it does now in the sense that we covered a very, very wide range of optional services. I think we covered all that were available at the time and have done so ever since. We now cover 28 out of the 31 optional services. There are only three states that cover more than that. It has been, for a decade or more, one of the most expensive Medicaid programs in the country on a per-recipient basis, which is a function both of the wide range of services we provide and the very generous reimbursement systems, compared to other Medicaid reimbursement systems, for all providers.

The federal government I think pays about 55% of Medicaid costs. In Indiana, they pay 63% of our costs and they have an awful lot to do with determining who is eligible and what the terms and conditions of services are. Especially in the last four or five years, the federal government has mandated much broader coverage, primarily for pregnant women and younger children, which has increased costs dramatically in this state and all around the country. Obviously, other factors driving the increase in costs in recent years have been the national recession bringing more people onto the rolls and also the fact that health care inflation has been going up about twice as fast as inflation in the rest of the economy. All of those factors affect Indiana and all other state Medicaid programs.



> ***"Especially in the last four or five years, the federal government has mandated much broader coverage, primarily for pregnant women and younger children, which has increased costs dramatically in this state and all around the country."***

INDIANA MEDICINE: **We've heard a lot recently about provider taxes. What do you see in Indiana's future regarding that kind of taxation?**

Verdier: It's obviously one of the areas that we're looking at to deal with the current budget problem that we have. But it's just one of probably eight general areas that we're looking at. Under federal legislation that was passed in late 1991, states are permitted to raise up to 25% of their state share in assessments on six specified classes of providers: hospitals and physicians, nursing homes, prescription drugs, home health agencies and a couple of others. These assessments have to be uniform and broad-based, that is, they have to apply equally to all providers in one of those designated classes, irrespective of how much Medicaid business they do or of anything else. If our state share of Medicaid stays at $800 million, which where it now is, and that's our goal, then we could, under federal law, raise up to $200 million in these kinds of provider assessments and have the federal government match those payments in the same way they would match general state tax revenues. We get, because of our matching rate, about $1.70 in federal money for each dollar we raise in the state.

INDIANA MEDICINE: **Is the provider tax option on the top of the pile of options being considered?**

Verdier: Right now, it is just a large pile, with everything we have been able to think of in it, and all contributions of additional ideas and suggestions are gratefully accepted because we have a situation in which our projected increase in Medicaid expenditures over the next two years is over $900 million. That's just the increase. Our projected increase in state revenues is about $800 million. So the projected increase in Medicaid expenditures will use up more than all of the new revenues that we anticipate. And with the other pressures on the state budget for increasing help for education and economic development and job training and all of the other things that we'd like to do, as well as all of the other social services and health programs that we'd like to support, it's simply

not going to be possible to do those things and fund that projected level of Medicaid increases. So we are looking at everything we can think of to bring that projected rate of increase down.

INDIANA MEDICINE: **Just to recap, what is the Medicaid budget here in Indiana?**

Verdier: Our current appropriation, the state's 37% share, is just under $800 million in fiscal year 1993. Our expenditures are projected to rise to just under $1.2 billion in 1994 and just under $1.4 billion in fiscal year 1995.

INDIANA MEDICINE: **How about a so-called "sin tax," for instance, on cigarettes? Would such a tax generate a substantial amount of revenue to lessen the burden of Medicaid on the state?**

Verdier: Well, the administration's position is that we are opposed to any tax increases. But to answer your factual question, the cigarette and tobacco tax in Indiana is about 15 and a half cents [a pack] now, and it raises just over $100 million. As a rough rule of thumb, for each penny increase, you could get another $6 million. So arithmetically, yes, it will raise $6 million for each penny of the increase. And you can figure how much revenue it would raise depending on what level it was at.

INDIANA MEDICINE: **Primary care case management systems have been implemented in other states but not in Indiana. What are your thoughts on that type of strategy toward containing health care costs?**

Verdier: I think it's a good idea because it's a better way of practicing medicine. I think it will improve access and quality of care in the sense that people will get better preventive care. They will not get excessive specialist care. They won't be going to emergency rooms and sitting there for three hours waiting to be treated for an ingrown toenail or something of that sort. It's just a better way of practicing medicine, and I think we want to move toward it for mainly that reason.

> ***"Our best estimate is that once we got a good physician primary care case management plan up and running, we could save perhaps $10 or $15 million a year, state and federal combined, which is worth something."***

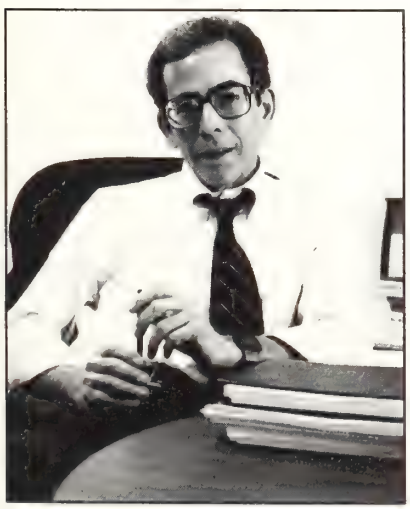
The experience in other states is that it does not save substantial amounts of money. Kentucky is one that is at least claiming large savings, although I have very substantial doubts about the volume of savings. Where it does save money is in reducing the overuse of emergency rooms and the overuse of specialists. A state like Kentucky that pays its primary care physicians very little – they rank, I think, 45th in the nation in physician reimbursement – has an awful lot of people going to emergency rooms and going to specialists because that's their only alternative. But, if you take a look at a state like Indiana, where our physician reimbursement is close to first in the nation, we haven't been able to find an extraordinary amount of emergency room utilization or specialist utilization. Dr. Denise Ingram-Bradley on our staff has been analyzing claims data for the last several months, and our total expenditures on emergency room care for AFDC plus pregnant women is not much more than $25 million, state and federal combined, out of a total budget of well over $2 billion. So if we cut it in half, even, that would not be a major savings. Our best estimate is that once we got a good physician primary care case management plan up and running, we could save perhaps $10 or $15 million a year, state and federal combined, which is worth something. But, when you're trying to fill a gap of $400 million in the state share of the Medicaid budget, it's not a lot. But we think it's worth doing because it's just a better way of practicing medicine, and I think in the long run we'll provide better care and better service for Medicaid recipients.

INDIANA MEDICINE: **When do you think Indiana will implement a primary care case management system?**

Verdier: We have to be able to convince the federal government that the program we have devised and proposed will save more money than doing things the way we have been doing them right along. I think we've got enough data together that we can probably

demonstrate that now. We haven't had the data to do that before. Then the federal government has 90 days to review that, and they are allowed to ask for more information on day 89, which they frequently do, which starts the 90-day clock running again. I should point out that the reason they're called waivers is that it requires waiving the normal requirement of Medicaid law, which is that recipients are entitled to free choice of providers. We would be restricting their choice of providers through this, and therefore that provision has to be waived.

But once we got federal approval, and they're fairly sympathetic to these kinds of waivers, the experience in other states is that it usually takes at least a couple of years to get these kinds of systems fully up and running. You've got to enroll providers. You have to set up a system for reporting on their experiences, how many times their patients go to emergency rooms and why. What was the use of specialists and why? Are certain physicians using emergency room specialists more often than others? Are they answering their 24-hour-a-day phone? And all of those kinds of things that you'd need to set up a responsible and accountable program. Getting that in place and up and running usually in other states has taken a year or two.



INDIANA MEDICINE: **What's your read on when that might happen in Indiana?**

Verdier: I hope we can submit the waiver within the next couple of months. It's a question of how long it takes to put the data together in the form that the federal government wants, and as I say, these kinds of waivers are easier to put together than most others. But I have yet to see a waiver [application] that was less than two inches thick.

INDIANA MEDICINE: **What sorts of ideas do you have for funding long-term care of patients in nursing homes under the Medicaid program?**

Verdier: I think what we'd like to do is something that probably half or more of the states are now doing, which is develop what's called a case mix system, in which reimbursement is tied fairly directly to the level and type of care. So if you have patients that really need intense care, they would be reimbursed at a higher rate. And if you have patients, maybe Alzheimer's patients, who don't have a lot of physical problems and don't require intensive nursing care, they would be reimbursed at a lower rate. States that have case mix systems have anywhere from four different levels up to as many as 10, and reimbursement is tied to the level of required care.

The federal government is now requiring states to establish what's called a minimum data set, which would provide information on the kind of care received by patients and the kind of care they need in all nursing facilities and could be updated every six months or a year. That's a federal requirement. Our department of health is now developing that. Once that's developed and in place, then we would have the data we would need to have that kind of a case mix reimbursement system and we would be able to get away from the system we now have, in which we still make a distinction between skilled and intermediate care for purposes of reimbursement. The rates are maybe $62 a day on average for intermediate care and $79 a day for skilled care. But they vary an awful lot from one facility to another depending on things like how long the facility has been in operation and whether they changed ownership, how skillful and creative their accountants are and a whole lot of things that are not necessarily closely related to the appropriate and legitimate costs of caring for patients.

I think we do want to move toward a system that has payments varying with the type and quality of care. But for each facility that provides that type and quality of care, they ought to all get the same rate across the state. Now there may be a reason for having some variation depending on rural versus urban if you can find, for example, systematic variation in nurses' salaries. But other than that, I don't see any

reason why the rates should vary for an equivalent type of care anywhere in the state.

INDIANA MEDICINE: **Is the case mix idea being considered?**

Verdier: Yes, and obviously right now an awful lot of these ways of revising the reimbursement system are on hold because we've been sued by the nursing home industry and that case is now before the Indiana Supreme Court. Until that gets decided, we really can't make any changes in the reimbursement system. Our hope is that it will be decided sometime in the next few months, but there are no guarantees.

INDIANA MEDICINE: **How do you think a case mix system of reimbursement would impact physicians?**

Verdier: We would probably need more physician input, more physician judgment on the condition of patients and how that relates to the type and level of nursing care that they require. To that extent I think there would be perhaps more involvement of physicians than there is now, where all they have to do is say if it is skilled or intermediate. Those are pretty broad, general categories, and obviously we review those judgments by physicians in those cases.

We have a staff that looks in detail at the patient's condition as recorded in the documentation provided to us, and sometimes we'll accept the physician's judgment on that and sometimes we won't. That obviously would continue, but I think as we have a system where reimbursement is tied more closely to maybe four, five different levels of care, that would probably require more refined, discriminating judgments on the part of physicians and others involved in the process to make sure people were at the appropriate level of care.

INDIANA MEDICINE: **How do you think it would impact physicians in terms of their reimbursement?**

Verdier: I don't believe there would be any direct link between nursing home reimbursement and physician reimbursement. Not one that I can think of, anyway.

INDIANA MEDICINE: **Do we have a Medicaid fee schedule in Indiana for physician reimbursement?**

Verdier: We don't. We're one of just a handful of states that don't. We rely on a quite outmoded system that depends heavily on physicians' prior billing experience. Another factor is the usual and customary charges in the community. You have a system, therefore, that can have a physician receiving an unusually low rate of reimbursement for a particular procedure or for an office visit, related primarily to what that physician may have been billing for that particular procedure several years ago, and be out of synch with what his or her peers in the community are reimbursed for the same procedure. There are a fair number of anomalous results of that sort that are frequently called to my attention by physicians who are chagrinned by that, and I think properly so.

We would like to move toward a standard fee schedule so that the rate for a particular procedure or office visit is pretty much the same for all physicians around the state. Again, there may be some basis for a rural versus urban distinction there. We also want to see whether our reimbursement for primary and preventive care is adequate, especially for obstetrical and gynecological care because that's something that's of special importance to Medicaid recipients, the increasing number of pregnant women and young children who are coming onto the Medicaid rolls. But we don't expect that kind of fee schedule system to be in place for more than a year or two.

What we would like to move toward is a version of the RBRVS system, the relative value scale system of reimbursement that Medicare is using. I think we want to see what the experience is in a few other states in their Medicaid programs with that kind of system because the RBRVS system was obviously developed with an older population in mind, and the system needs refinement and adaptation to make it appropriate for a younger population, for pregnant women and people who are not in the Medicare age groups.

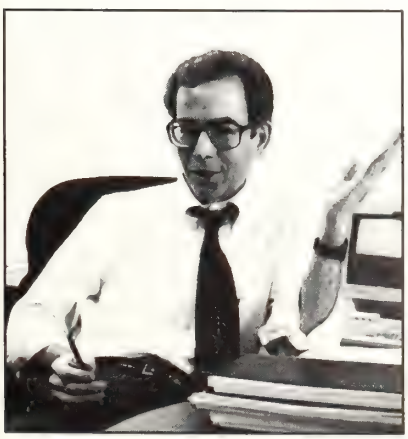
That kind of development work is taking place in several states around the country, and our hope is that within a year or two there will be something pretty much off the shelf that we can bring in and use in Indiana. Obviously this is an area where we would want to work real closely with the physician community in making sure that we adapted it properly to the Medicaid population.

This system has a major

advantage in that it's designed to provide greater or more appropriate reimbursement for primary kinds of care and reduced reimbursement for high-tech, specialty kinds of care. I think that's the direction we want to go in the Medicaid program, and having this RBRVS system available will enable us to do that. It also ought to simplify things a bit for physicians because my expectation is that a lot of private insurance companies are going to be using this system. Obviously Medicare does and that would make the systems more unified, and I hope would ease some of the billing hassle that I know physicians experience.

INDIANA MEDICINE: **Do you foresee co-payments by patients for optional Medicaid services in Indiana?**

Verdier: That's one of the issues that is on the table to deal with the budget problem we're now facing. It doesn't raise a lot of revenue. There are, under federal law, significant exclusions. You cannot impose co-payments on pregnant women or children or people in institutions, hospitals or nursing homes. You can't impose them for emergency services. Also, the co-payments are quite small. It's 50 cents for services up to $10 and no more than $3 co-payments for services costing $50 or more. So those limitations of federal law limit to some extent the revenue you can get.



Our rough estimate is that if we applied co-payments in all the areas that we're permitted, and we're permitted to apply them to both the mandatory and the optional services, we could raise in co-payments directly maybe $6 million a year and, as a rough rule of thumb, perhaps save additional amounts because of reduced utilization of perhaps half of that. Add another $3 million in savings to that, which, again, in the context of having to fill a gap of several $100 million, is not a lot.

INDIANA MEDICINE: **What kind of impact do you think that kind of co-payment for optional Medicaid services by patients would have on physicians?**

Verdier: Under federal law, it would be their responsibility to collect the co-payments, and what effect that might have on their relationship with their patients is unclear. They obviously collect co-payments and deductibles from their private-pay patients all the time, so it's not an unfamiliar process for them to go through. Conceivably in some cases, especially when you're dealing with a population that's as poor as people are in the Indiana Medicaid program, and we have unusually strict income eligibility rules here, there will be some people who can't come up with 50 cents, or a dollar, and they may not come in for the check-up or the preventive care that it would be appropriate for them to come in for. Obviously, as we look at co-payments, that's an issue that we have to be concerned with.

But federal law does exclude from co-payments those categories of recipients and those situations where the hardship or the potential for that kind of under-use is greatest, and that's the pregnant women and children and emergency situations. So to some extent, the biggest potential problems are not areas that would be covered by co-pays at all.

INDIANA MEDICINE: **What is your sense about the likelihood of co-payment for optional Medicaid services being implemented in Indiana?**

Verdier: That's probably too hard for me to predict with any reliability at this point. My sense is that an awful lot of these issues will not finally be resolved until the last few weeks of the legislative session. There's an awful lot of discussion and consultation that we need to go through before we or the legislature or anyone else is really in a position to make those kinds of decisions.

We do have in place, or almost in place, co-payments for certain transportation services. The regulations are moving through the process. As soon as they're through, we'll institute those co-payments, probably sometime this spring. That will give us some experience with the administrative impact on both our claims processor and the provider community from co-payments and give us also

a sense of what impact they might have on utilization and whether they're preventing people from going to appropriate medical care. So we'll learn some things that will be useful carry-over lessons.

INDIANA MEDICINE: **Historically, Medicaid reimbursement has been more than Medicare. Is that correct?**

Verdier: That is the case in Indiana but in scarcely any other Medicaid program in the country.

INDIANA MEDICINE: **However, as I understand it, Medicaid now pays less than Medicare?**

Verdier: Not according to the most recent data that I have seen. The most recent data I've seen indicates that we are paying 18% more than Medicare on average, and we are number one in the nation, compared to other Medicaid programs, by that measure. There is no other Medicaid program that pays that much more than Medicare. Indeed, the national average is something like 75% of Medicare.

INDIANA MEDICINE: **Whereas in Indiana ...**

Verdier: We pay 118%.

INDIANA MEDICINE: **In the near future, would one expect to see a trend of declining Medicaid reimbursements relative to Medicare?**

Verdier: I would certainly think so. If you're looking at areas where there is some potential for cost containment, the first place you look is where we depart very substantially from the norms of other states. We pay very much more than the surrounding states in hospital reimbursement, in physician reimbursement, transportation reimbursement, home health care reimbursement, nursing home reimbursement. Across the board, we systematically pay higher rates of reimbursement for almost all providers in Indiana than in any of the surrounding states or in just about the whole remainder of the country.

> ***"The most recent data I've seen indicates that we are paying 18% more than Medicare on average, and we are number one in the nation, compared to other Medicaid programs, by that measure."***

INDIANA MEDICINE: **So even though Medicaid is still reimbursed at a higher level than Medicare in Indiana, that may not necessarily be true a year from now?**

Verdier: It is certainly not a legal requirement or a policy goal in Indiana to pay more than the Medicare program for Medicaid. State Medicaid programs are funded in part by state tax dollars, and unlike the federal government, we can't run deficits. We have certain constraints on what we can do with our dollars that seemingly do not confine the federal government in the decisions they make, and Medicare is a 100% federally funded program.

INDIANA MEDICINE: **I'd like to follow up on something you mentioned earlier about a new computer system.**

Verdier: This is a new, sort of state-of-the-art Medicaid management information and claims processing system to replace our current system, which is now about 17 years old. This will enable us to do a much better job of processing claims from physicians and others more quickly and more accurately and will also enable us to tell physicians right up front all the things they need to do to correct any errors and omissions in their claims.

The way our existing system works, it basically sends back the claim on the basis of the first error it finds. It doesn't go through and systematically find all the errors and omissions and print out instructions on how to fill out and send in a corrected claim. The reason is because the technology 20 years ago really didn't permit a system to do that, but that's the kind of system we've had to live with. It's been a problem for us and a problem for providers. I think the new system will enable us to make major improvements in that area and in a whole lot of areas of claims processing. We'll be able to do a much better job of paying claims in a timely and accurate fashion, which will be of benefit to providers and to us. This system will also produce for

us much better data on trends and patterns in the provision of Medicaid services all across the board. We'll have a much better analytic policy development capability than we've had before. We have just awarded a contract to EDS, after competitive bidding, to put this new system in place and have it up and running by July 1, 1994. They will be starting within the next couple weeks to start putting this new system in place. We'll have an extended period time for testing and development, to make sure that the transition between the old system and the new system is as seamless and trouble-free as we can possibly make it.

INDIANA MEDICINE: **How do you think the change of administration in Washington will affect Medicaid, nationally and in Indiana?**

Verdier: It's hard to predict because President Clinton was a former governor, and he's seen what the impact has been on state budgets of all of the additional mandates and other pressures the federal government has placed on the states in the Medicaid program. Indeed, Arkansas has had to make very dramatic cutbacks in eligibility and provider reimbursement. They've eliminated lots of optional services just in the last year or so, so he's had direct experience with that. But he's now the president, and he's got the federal budget deficit that is driven in considerable measure by increasing costs of health care, Medicare and Medicaid. So his flexibility to be helpful to states in a fiscal sense is somewhat limited. But there are ways in which he could help both the federal budget and state Medicaid by giving states a bit more flexibility than they now have in determining appropriate levels of service: which services are covered and to what extent; what reimbursement systems look like; what the appropriate criteria are for those systems and what kinds of things are necessary to preserve adequate access and quality of care. For many of those things, we are under pretty strict prescriptive rules that have been imposed by the federal government, and if states were given a bit more flexibility, I think we might be able to deliver care in more cost-effective ways. That would save states like Indiana money, and it would also save the federal government money because their 55% share of the cost would be less.

On my more hopeful days, I think that's the direction the Clinton administration is likely to go. On my more pessimistic days, I look back and wonder whether they're going to be continuing to impose extra mandates on us that increase our costs or even shift costs that are now borne by the federal government onto Medicaid. Medicaid has picked up in the last few years a number of burdens that in my view should properly be with the Medicare program. We're paying, for example, copayments and deductibles and premiums for low-income Medicare recipients out of the Medicaid program. In my view, that ought to be covered by the federal Medicare program. But that burden has been dumped on the states.

INDIANA MEDICINE: **Do you have any other comments?**

Verdier: No, other than to emphasize what an extraordinarily difficult problem we have because of the growth in the Medicaid program in Indiana. It's been growing at a rate of 20% a year for the last four years, and our revenues have only been growing 3% or 4% a year. Those trends are projected to continue into the future, and there's simply no way that we can support the Medicaid program at the level that it is projected to reach without really wiping out everything else that we'd like to do in the remainder of the state budget or having very, very major tax increases. And I simply don't think there is public support out there for tax increases of that magnitude.

It's a very, very serious problem, and it's one that we want to able to work with all the health care provider community, with the legislature, with representatives of Medicaid recipients and other advocacy groups to see if we can work our way toward a solution. Because it's going to require a fair amount of pretty painful decisions, and we'd like to have everybody participate in that as much as possible, to make sure we do it with the least pain and disruption that we can achieve, understanding that none of it is going to be easy. ❑

This interview was conducted by Bob Carlson, a health care communications consultant in Indianapolis.

HIV seroprevalence in the Bell Flower STD Clinic

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The Indiana State Department of Health (ISDH), in cooperation with the Centers for Disease Control (CDC), conducted a series of HIV seroprevalence studies in the Bell Flower Sexually Transmitted Disease (STD) Clinic in Indianapolis annually from 1990 through 1992.

The surveys were designed to estimate the HIV seroprevalence rate in people who use the Bell Flower STD Clinic for examination and treatment of STDs such as gonorrhea, chlamydia and syphilis. People who used the STD clinic solely for HIV testing were excluded, minimizing the chance of self-selection bias among survey participants. These surveys were part of the CDC-sponsored Family of HIV Seroprevalence Surveys performed across the United States and designed to estimate the HIV seroprevalence rate in selected populations, such as STD clinic patients, people enrolled in substance abuse programs, prisoners, tuberculosis patients, women's health center patients and adolescent health clinic patients.

Methods

The survey was unlinked, with no patient's name included with the specimen. The survey used waste blood left over from the RPR (Rapid Plasma Reagin) syphilis screening test performed on each person examined for STDs. The RPR was performed on each patient, and if the result was positive, RPR quantitation and FTA-Abs confirmation were performed.

After those tests, the patient's name was removed from the left-over serum specimen, and an anonymous number, which corresponded with the number on the HIV data sheet, was assigned. The HIV data sheet requested information on the month/year of clinic visit, age group, race/ethnicity, gender, risk exposure, STD diagnosis, state/county/zip code of residence, reason(s) for visiting the clinic and referral source. All information requested on the HIV data sheet was collected by the clinic for other purposes.

After the HIV data sheet was completed by the health professional examining the patient, the unlinked serum specimen and HIV data sheet were sent to the ISDH laboratory for HIV testing and data entry. Informed consent was not necessary since the serum specimen was waste blood, the demographic data was collected for other purposes and the results were double-blinded. People using the STD clinic more than once during the survey period and patients whose sole reason for coming to the STD clinic was to be HIV tested were excluded.

Each of the three annual surveys collected all specimens, male and female, until a minimum of

Table 1

HIV seropositivity by gender and survey period

	Survey Period					
	1		2		3	
	Men	*Women*	*Men*	*Women*	*Men*	*Women*
Number tested	900	558	914	543	951	542
Number positive	14	0*	17	1*	14	4*
Rate	1.56%	0	1.86%	.18%	1.47%	.74%

* Chi-Square Test for trend in HIV seropositivity among women = 4.91, p = .027.

500 women were sampled in each of the three survey periods. As a result, more men than women were sampled in each survey period. HIV seropositivity was defined by a repeatedly reactive ELISA test (Abbott Laboratories) and a reactive western blot confirmatory test (Ortho-Cambridge Biotech). Western blot reactivity was determined by the presence of at least two viral protein bands from either p24, gp41 or gp120/160. Chi-square tests for trend were performed on EpiInfo software.[1]

Results

Survey period 1 began March 1, 1990, ended June 15, 1990, required 66 clinic days of operation to complete, and enrolled 1,458 people. Survey period 2 began March 11, 1991, ended April 26, 1991, required 35 clinic days of operation to complete, and enrolled 1,457 people. Survey period 3 began March 9, 1992, ended April 17, 1992, required 30 clinic days of operation to complete, and enrolled 1,493 people.

The HIV seroprevalence studies at the Bell Flower STD Clinic all began in the month of March, making yearly comparisons of HIV seroprevalence more valid.

Study population demographics – The study populations for each survey period were similar by gender *(Table 1)*, race/ethnicity *(Tables 2, 3 and 4)* and age group *(Table 5)*. Although some variability is present in the demographic distribution of gender, age group and race/ethnicity between the study populations by survey period, the differences were not statistically significant and suggest that the overall demographic distribution of Bell Flower STD Clinic patients is similar from year to year. The reported risk exposures for men and women were consistent across each survey period, further supporting the hypothesis that the study populations were similar for each survey period.

HIV seroprevalence rates by demographic and risk exposure characteristics – The crude HIV seroprevalence rate (number HIV positive divided by the number tested) for survey period 1 was 0.96% (14/1,458), 1.24% (18/1,457) for survey period 2 and 1.21% (18/1,493) for survey period 3. The crude HIV seroprevalence rate did not significantly increase or decrease between the three survey periods. HIV seropositivity rates, by gender, are summarized in *Table 1* for the three survey periods.

HIV seroprevalence for men did not significantly increase or decrease between the three survey periods; however, the HIV seroprevalence rate among women did significantly increase (X^2 test for trend = 4.91, p = .027) between the three survey periods, from 0% the first year, to 0.18% the second year, to 0.74% the third year. HIV seropositivity by race/ethnicity is outlined in *Table 2* for the three survey periods.

HIV seropositivity decreased for whites during each survey period (1.91% in 1990, 1.29% in 1991 and 1.17% in 1992) while HIV seropositivity among African-Americans increased during each survey period (0.43% in 1990,

Table 2

HIV seropositivity by race/ethnicity and survey period

	Survey Period 1	2	3
White			
Number tested	523	466	597
Number positive	10	6	7
Rate	1.91%	1.29%	1.17%
African-American			
Number tested	921	971	885
Number positive	4	11	11
Rate	.43%	1.13%	1.24%
Hispanic/Other			
Number tested	14	20	11
Number positive	0	1	0
Rate	0	5%*	0

* This percentage is based on a small cell number and should be interpreted with caution.

1.13% in 1991 and 1.24% in 1992). However, these changes in HIV seropositivity were not statistically significant. The trend becomes more evident when HIV seropositivity was evaluated by race and gender as depicted for men in *Table 3* and women in *Table 4*.

HIV seropositivity decreased for white men during the three survey periods while no clear pattern was apparent among African-American men. Neither group showed any statistically significant trend in HIV seropositivity.

HIV seropositivity showed a statistically significant increase among African-American women, from 0% in 1990, to 0.26% in 1991, to 1.27% in 1992. Consequently, the statistically significant increase in HIV seropositivity identified for women in *Table 1* can be attributed to the increase in HIV seropositivity among African-American women during the three survey periods, since no white or other racial/ethnic women tested HIV positive. HIV seropositivity by age group is summarized in *Table 5* for three survey periods.

Participants aged 35 to 39 were the only patients to show an increased rate of HIV seropositivity; however, the trend was not statistically significant. All other age groups showed no statistically significant increasing or decreasing trend in HIV seropositivity.

HIV seropositivity for men by risk exposure category showed no statistically significant increases or decreases by survey period, with the highest rates of HIV seropositivity found in men who report having had sex with other men. The HIV seropositivity rate among men who reported having

Table 3

HIV seropositivity for men by race and survey period

	Survey Period		
	1	**2**	**3**
White			
Number tested	339	312	373
Number positive	10	6	7
Rate	2.95%	1.92%	1.88%
African-American			
Number tested	552	588	570
Number positive	4	10	7
Rate	.72%	1.70%	1.23%
Hispanic/Other			
Number tested	9	14	8
Number positive	0	1	0
Rate	0	7.14%*	0

* This percentage is based on a small cell number and should be interpreted with caution.

Table 4

HIV seropositivity for women by race and survey period

	Survey Period		
	1	**2**	**3**
White			
Number tested	184	154	224
Number positive	0	0	0
Rate	0	0	0
African-American			
Number tested	369	383	315
Number positive	0*	1*	4*
Rate	0	.26%	1.27%
Hispanic/Other			
Number tested	5	6	3
Number positive	0	0	0
Rate	0	0	0

* Chi-square Test for trend in HIV seropositivity among African-American women = 5.69, p = .017.

Table 5

HIV seropositivity by age group and survey period

	Survey period 1 *			Survey period 2 •			Survey period 3		
	#Test	#Positive	Rate	#Test	#Positive	Rate	#Test	#Positive	Rate
< 15	8	0	0	9	0	0	8	0	0
15-19	302	0	0	305	1	.33%	290	1	.34%
20-24	482	4	.83%	477	4	.84%	479	2	.42%
25-29	286	5	1.75%	296	4	1.35%	292	5	1.71%
30-34	183	3	1.64%	182	3	1.65%	189	2	1.06%
35-39	90	1	1.11%	91	3	3.3%	129	6	4.65%
40-44	56	0	0	52	2	3.84%	46	1	2.17%
45+	46	1	2.47%	43	1	2.33%	60	1	1.67%

* = Five study participants from survey period 1 were missing age group information and were excluded from this analysis.

• = Two study participants from survey period 2 were missing age group information and were excluded from this analysis.

had sex with other men was 28.6% (8/28) for survey period 1, 36.4% (12/33) for survey period 2 and 27.6% (8/29) for survey period 3. HIV seropositivity for heterosexual men was less than 1% for each survey period.

Women, however, showed a statistically significant increase in HIV seropositivity (X^2 test for trend = 4.87, p = .027) among women who report heterosexual contact as their only exposure to HIV. The rate went from 0% (0/551) for survey period 1, to 0.18% (1/525) for survey period 2, to 0.75% (4/534) for survey period 3. Therefore, the profile of a woman most likely to be HIV positive at the Bell Flower STD Clinic would include African-American race and heterosexual contact as their risk exposure. The characteristic most likely present in an HIV positive man would be one who engaged in male-to-male sex, regardless of race/ethnicity.

HIV seroprevalence by residence zip code – Each patient enrolled in the HIV seroprevalence survey had a zip code and county of residence entered on the form. Most study participants reported Marion County as their county of residence. Zip codes 46205, 46218, 46222 and 46226 all showed increased numbers of HIV positive individuals, by survey period, for those who went to the Bell Flower STD Clinic for an STD evaluation and treatment. Three of these four zip codes (46205, 46218 and 46226) are in the near northeastern part of Indianapolis, roughly representing an area bordered on the west by Meridian Street, north by 52nd street and the Fall Creek Parkway, east by Post Road and south by 22nd Street. The remaining zip code (46222) is on the near west side and is bordered on the west by Georgetown Road, north by 38th Street, east by the White River and south by West Washington Street.

HIV seroprevalence surveys also were performed in STD clinics located in Fort Wayne and Evansville in 1991 and 1992. The methods, procedures and inclu-

sion/exclusion criteria were identical to the surveys performed in the Bell Flower STD Clinic, making comparisons possible. Due to lower patient volume in both Evansville and Fort Wayne, the sample size was set at 500 patients for each STD clinic and survey period, with a minimum of 100 women screened. The survey took approximately six months to complete in the Evansville STD Clinic for 1991 and 1992, while the sample size was attained in seven weeks in the Fort Wayne STD Clinic for 1991 and 1992. The HIV seroprevalence rate in the Evansville STD Clinic for 1991 was 0.59% (3/506) and 0.39% (2/516) for 1992. The HIV seroprevalence rate for the Fort Wayne STD Clinic was 0.18% (1/560) in 1991 and 0.39% (2/514) in 1992.

Discussion

Between June 1988 and December 1989, the Centers for Disease Control sponsored and published HIV seroprevalence data on 103 STD clinic surveys located in 38 metropolitan areas across the United States. The median HIV seroprevalence rate was 2.2%, with a range of 0% to 38.5%.[2] Although the HIV seroprevalence rates found in the Bell Flower, Fort Wayne and Evansville STD clinics, for any of the survey periods, were below the national median HIV seroprevalence rate, the increased percentage of HIV positive African-American women found in the Bell Flower study is an area of concern for HIV/AIDS prevention programs.

HIV/AIDS surveillance data showed 6% of Indiana AIDS cases, and 14% of reported Indiana HIV infections were among women. As the HIV/AIDS epidemic continues to shift toward women, the potential exists for increased numbers of HIV-infected children and pediatric AIDS cases. HIV/AIDS surveillance also shows that Indiana minority populations are disproportionately affected by the HIV/AIDS epidemic. For instance, African-Americans comprise 7.8% of Indiana's population, while constituting 18% of Indiana AIDS cases and 27% of reported Indiana HIV-infected people. The HIV seroprevalence data from the Bell Flower STD Clinic studies support the observed shift in HIV/AIDS cases toward women and minority populations for which HIV/AIDS prevention programs must be designed and implemented in the future.

The HIV seroprevalence data from the Bell Flower STD Clinic studies support the observed shift in HIV/AIDS cases toward women and minority populations for which HIV/AIDS prevention programs must be designed and implemented in the future.

Limitations

The population surveyed at the Bell Flower STD Clinic does not represent the general population of Marion County. For instance, the percentage of STD clinic patients who are African-American (approximately 60%) is not equivalent to the 1990 census percentage of African-Americans in Marion County (21.2%). Even with the over-sampling of African-Americans in these surveys, the increased percentage of HIV positive women is significant and merits programmatic planning and changes.

The difference in the number of clinic days required to perform each of the three Bell Flower surveys (66, 35, 30) is a concern. During survey period 1, perhaps all eligible patients were not enrolled or the census of patients greatly increased during the second and third survey periods.

The HIV seroprevalence surveys performed at the Bell Flower, Evansville and Fort Wayne STD clinics are the only unbiased estimates of HIV seropositivity that exist for any clinic-based population segment of Indiana. Future studies will add to the database of HIV seropositivity for Indiana residents. ❑

Both authors were with the Indiana State Department of Health, Epidemiology Resource Center, at the time this paper was written. Minshall is now with Eli Lilly and Co.

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The ISDH thanks the following people for their contributions to the

HIV seroprevalence studies: Virginia Caine, M.D., medical director of the Bell Flower Clinic and acting director of the Marion County Health Department; Roberta Fisher, RN, director of nursing for the Bell Flower STD Clinic; Robert Johnson, public health adviser to the Bell Flower Clinic; Jim Beall, director of the Indiana STD Program; the Bell Flower STD Clinic nursing and clerical staffs; the staff at the Fort Wayne and Evansville STD Clinics; and Gregory V. Hayes, DrPH, director of the ISDH Laboratory Resource Center.

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References

1. Dean AD, Dean JA, Burton AH, Dicker RC: *EpiInfo, Version 5: A word processing, database and statistics program for epidemiology on micro-computers.* USD Inc., Stone Mountain, GA: 1990.

2. *National HIV Seroprevalence Surveys: Summary of Results, Data from Serosurveillance Activities Through 1989.* U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control: HIV/CID/9-90/006.



State program tracks Schedule II drugs

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Editor's note: An editorial on the Indiana State Medical Association position on the Indiana Multiple Copy Prescription Program appears on page 126 of this issue. Two bills on the program were introduced in the Indiana General Assembly. The ISMA supports Senate Bill 504, as introduced by Sen. Pat Miller, R-Indianapolis, which calls for the electronic data transfer mentioned in this article. The ISMA opposes House Bill 1674, as introduced by Rep. Vern Tincher, D-Riley, which continues the current Multiple Copy Prescription Program.

Drug abuse represents one of the greatest public health challenges of the 20th century, and the non-medical use of prescription drugs is a serious component of this problem. Surveys of drug treatment facilities have found that approximately 10% of patients admitted to these facilities were taking prescription drugs that were diverted from their intended use.[1-3] Accordingly, many states have enacted legislation to deal with the diversion of prescription drugs to curb abuse.[4]

In 1989, Indiana enacted legislation to track prescriptions to prevent diversion of controlled substances. Every practitioner who writes a prescription for a Schedule II pharmaceutical is required to use a multiple copy prescription form provided by this program. Indiana is one of 11 states, including Illinois and Michigan, that track Schedule II drugs. Advanced tracking systems using electronic data transfer have been implemented in Oklahoma, Massachusetts and Hawaii.[1] These more sophisticated electronic systems also track other drugs.

The purpose of prescription monitoring programs is to identify illegal diversion of Schedule II drugs and thereby identify "doctor shoppers." This program also identifies practitioners involved with personal abuse (impaired practitioners) or with criminal diversion of controlled substances.[5]

This article reviews Indiana law, including its strengths and weaknesses. An overview of the program and a description of data obtained from the Indiana Health Professions Bureau for 1991 are presented.

The program

Indiana law requires every person who manufactures or distributes a controlled substance within the state to obtain a registration issued by the Indiana State Board of Pharmacy. In addition, federal law requires registration with the federal Drug Enforcement Administration (DEA). A registration issued to a dispenser expires whenever the license of the practitioner expires.

Controlled substances are classified into five categories according to the following federal guidelines:

1) Schedule I – Drugs of high potential for abuse with no accepted medical use for treatment in the United States. These drugs lack accepted safety for use in treatment under medical supervision (e.g., heroin, crack/cocaine and hashish).

2) Schedule II – Drugs with high potential for abuse. These compounds currently have accepted medical use in treatment. However, these drugs have severe restrictions in use and abuse may lead to psychological and physical dependence (e.g., morphine, Demerol, amphetamines and codeine).

3) Schedule III – Drugs with less abuse potential than Schedule II, which have accepted medical use for treatment in the United States. The long-term use of these drugs may lead to moderate physical dependence with moderate to high psychological dependence. Sedatives and hypnotics are included in this group (e.g., pentobarbital, secobarbital and chlorhexadol).

4) Schedule IV – Drugs with moderate to low potential for abuse. These drugs have current accepted medical use in the United States, and the long-term use may result in limited, if any, physical dependence with moderate psychological dependence (e.g., benzodiazepines).

5) Schedule V – Drugs with low to non-existent potential for abuse. These drugs have common accepted use in the United States and have limited to non-existent physical or psychological dependence relative to their use (e.g., over-the-counter cough syrups and antidiarrheals).

The data in this article relate to the tracking of Schedule II

drugs that were obtained from triplicate prescriptions submitted to the Health Professions Bureau by pharmacies *(Tables 1, 2 and 3)*. In 1991, there were 245,682 Schedule II prescriptions issued by eligible practitioners. Pharmacies and practitioners who dispense or administer in their office are required to send their copies of triplicate prescriptions by the 15th of the month after the prescription was issued. The prescription copies are bundled by the date in which they were received at the Health Professions Bureau. Once every two weeks, five data entry clerks separate the copies by drug name and strength. Each drug and strength is assigned a predetermined code. Once prescriptions are coded, the data entry clerks enter each prescription into a computer system for data analysis. Approximately 300 prescriptions are entered per clerk per day during data tabulation. Approximately 28,000 prescriptions per month are processed.

The cost for administering this program in 1991 was $126,028, including salaries and benefits for employees. The operational cost for the program was $23,500, including postage costs, printing and supplies.

Table 1 lists the most commonly prescribed Schedule II drugs in Indiana for 1991. Methylphenidate (Ritalin) is the most commonly prescribed drug, typically prescribed by pediatricians for children with attention deficit disorder. One criticism of the current program is that this particular compound has little potential for abuse and addiction, yet it is monitored closely. Benzodiazepines (Schedule IV) have high psychological and moderate physiological dependence yet are unmonitored by the triplicate prescription program.

Table 1

Most commonly prescribed Schedule II drugs in Indiana: 1991

Schedule II drug	# Prescriptions/year
1) Methylphenidate (Ritalin)	97,360
2) Oxycodone (Percocet)	36,155
3) Oxycodone (Tylox)	25,976
4) Oxycodone (Percodan)	14,452
5) Meperidine HCL (Demerol HCL Tablets)	8,347
6) Morphine Sulfate (Contin Tabs)	7,965

The top medical specialty prescribers in 1991 included family physicians, pediatricians, internists, medical oncologists, psychiatrists and general surgeons. The non-physician prescribers are dentists and oral surgeons who prescribe analgesics *(Table 3)*. Identifying practitioners by medical specialty dispels concern about practitioners being singled out for their prescribing habits. For example, an oncologist, who will write more prescriptions for Schedule II medications than a cardiologist, will not have inappropriate action taken against his license for legitimate prescribing activity.

Confidentiality - practitioners and patients

The confidentiality of the triplicate prescription program is protected by Indiana law. If the Health Professions Bureau suspects a practitioner of over-prescribing a Schedule II drug, information cannot be released to law enforcement authorities unless it is reviewed and approved for release by a member of the Indiana Controlled Substance Advisory Committee. The committee member who reviews the prescribing activities must be a practitioner who is licensed in the same profession as the practitioner who is scrutinized. Law enforcement officers involved with drug diversion investigations by the Indiana State Police and federal DEA may access information from the program, but the officers first must be approved by the Indiana Controlled Substance Advisory Committee and demonstrate that the information requested is related to an investigation for prosecution of a controlled-substance related crime. Any public servant who intentionally releases confidential information related to this program commits a Class A misdemeanor.

Current research involving population-based clinical studies suggests that over-utilization of Schedule II drugs is infrequent.[1-3]

Most research suggests that significant underutilization of drugs occurs. This concern is particularly significant in large sub-populations of patients with severe pain and anxiety disorders. Practice parameters for the use of drugs, particularly in pain control, are in the process of being developed by various medical organizations.

Psychoactive drugs are prescribed for unapproved indications at times and at higher doses depending upon the clinical circumstance. Current federal health policy officials recognize that the use of approved drugs for unapproved indications at times is medically desirable and should be judged appropriately based on local medical standards.

Criminal investigations

The multiple copy prescription program is primarily designed to track illegal diversion. Since the program began, there have been more than 150 criminal investigations. "Doctor shoppers" are the target of 75% of these investigations, and practitioners were investigated in the remaining 25%. To date, 21 people have been arrested based on information from this program. Two of those arrested were practitioners.

Strengths of current programs

Establishing the Indiana Multiple Copy Prescription Program was a positive step toward controlling the diversion of Schedule II pharmaceuticals. By creating a paper trail, the program allows law enforcement officers to identify potential abusers at an earlier stage.

Indiana State Police narcotics investigators have reported a dramatic decrease in the illegal drug trade since the implementation of the new law. According to the investigators, the street value of these drugs has doubled and even tripled. In fact, the street price of a single 4 mg Dilaudid tablet is as high as $70.

The program has a deterring and limiting effect on those involved with Schedule II diversion, requiring physicians to write a prescription for a Schedule II drug on a serialized prescription form provided by the state. Because a pharmacy cannot fill a prescription not written on one of these forms, it reduces the possibility that the prescription is from a stolen pad written by someone besides the doctor. The program also may be a deterrent because those involved with the illegal diversion of Schedule II drugs know they can be identified.

Unwary physicians are protected from patients who take advantage of their prescribing privileges. Furthermore, the program reiterates to physicians the responsibility they have as prescribers and reminds them of the care they should take when prescribing highly addictive drugs.

Criticisms of the program

One criticism of the program is that it has had a "chilling effect" on how physicians treat patients. Critics assert that doctors fear being investigated by those involved with drug enforcement. The theory is that if doctors fear investigation, they will hesitate to prescribe a Schedule II drug to a patient who needs it. However, there is no proof that the program has this effect.

A survey conducted in Michigan reported that 80% of the physicians surveyed indicated that the program does not prevent them from prescribing Schedule II substances to patients who need it. The results in Indiana probably would be similar if an analogous survey were conducted. Until opponents of the multiple copy prescription program present concrete data that it has negative effects, this criticism is weak.

Some critics say the program violates the privacy rights of patients. They argue that the physician/patient confidential relationship is compromised because a patient's prescription record is

Table 2

Top medical specialty prescribers of Schedule II drugs in Indiana: 1991

Specialty	# Prescriptions/year
1) Family practice	65,889
2) Pediatrics	48,451
3) Internal medicine	24,289
4) Medical oncology	20,382
5) Psychiatry	16,492
6) General surgery	5,874

disclosed to people who handle records and, possibly, to investigators. However, the confidentiality of prescription information is protected by law. If the Health Professions Bureau suspects a practitioner is over-prescribing or is involved in drug diversions, information cannot be released to law enforcement officials or the Indiana attorney general unless it is first reviewed and approved for release by a member of the Indiana Controlled Substance Advisory Committee who is licensed in the same profession as the practitioner in question. By requiring approval, the program protects the confidentiality of patients as much as possible.

Limitations

Implementing a program designed to assist drug enforcement investigators with identifying drug diversion is important. However, some forms of tracking are more efficient than others. The multiple copy prescription program in Indiana is limited because it relies on a hand-written, mailed form for tracking. After the Health Professions Bureau receives prescription information, the information is entered into a computer for more efficient tracking. The time lapse between when the prescription is dispensed and when the information is available on-line is a limiting factor for Indiana's current program. The fact that officials are unable to quickly identify potential doctor shoppers or physicians involved with diversion makes the enforcement procedure less effective. There is also the risk that prescriptions will not be entered if there is a clerical backlog.

The lapse in time between dispensing and entering into the computer could possibly be eliminated if the information were entered immediately by the pharmacists. Such a system, called the Electronic Data Transfer, is now in place in Oklahoma and Massachusetts. The system requires the pharmacist to enter patient information, the date, the quantity of drug dispensed and information about the prescribing physician.

Proponents of this system stress the confidentiality it offers, since the physician and patient are not included in the process. Patient confidentiality is not compromised because the only people who see the information are investigators. Most important, however, is the fact that the information is immediately available for investigative purposes.

Table 3

Top non-physician medical specialty prescribers of Schedule II drugs in Indiana: 1991

Specialty	#Prescriptions/year
1) Dentistry	16,388
2) Oral surgery	4,051
3) Podiatry	2,497
4) Veterinary medicine	1,207

Summary

By implementing the multiple copy prescription program, Indiana demonstrates its concern with the problems of doctor shoppers and physicians involved with abuse. By trying to track illegal diversion of Schedule II drugs, states that have implemented tracking programs are trying to rid the streets of illicit drug use.

When it is time to renew the law, the state should consider using modern computer technology. Indiana's program could be even more effective if it incorporated electronic data transfer. ❑

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References

1. Cooper JR, Czeckowicz DJ, Petersen RC, Molinari, SP: Prescription drug diversion control and medical practice. *JAMA*, 268:1306-1310, 1992.

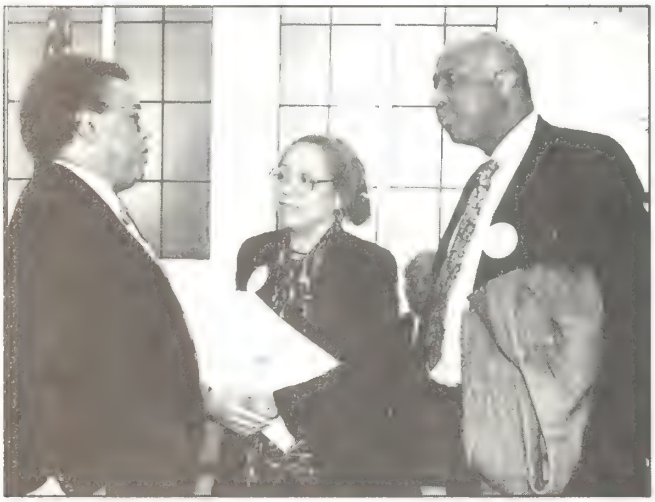
2. Adams EM: Prevalence of prescription drug abuse: Data from the National Institute on Drug Abuse. *NY St J Med*, 91:337-341, 1991.

3. Haislip GR: Scope of prescription abuse. *Substance Abuse*, IV:4, 1982.

4. Hollister AS: Drug abuse policy. *Science*, 252:11, April 5, 1991.

5. Hollister AS: Patterns of scheduled drug prescribing abuse by Tennessee physicians. *Substance Abuse*, 11:69-78, 1990.

Physicians visit Statehouse during Medicine Day



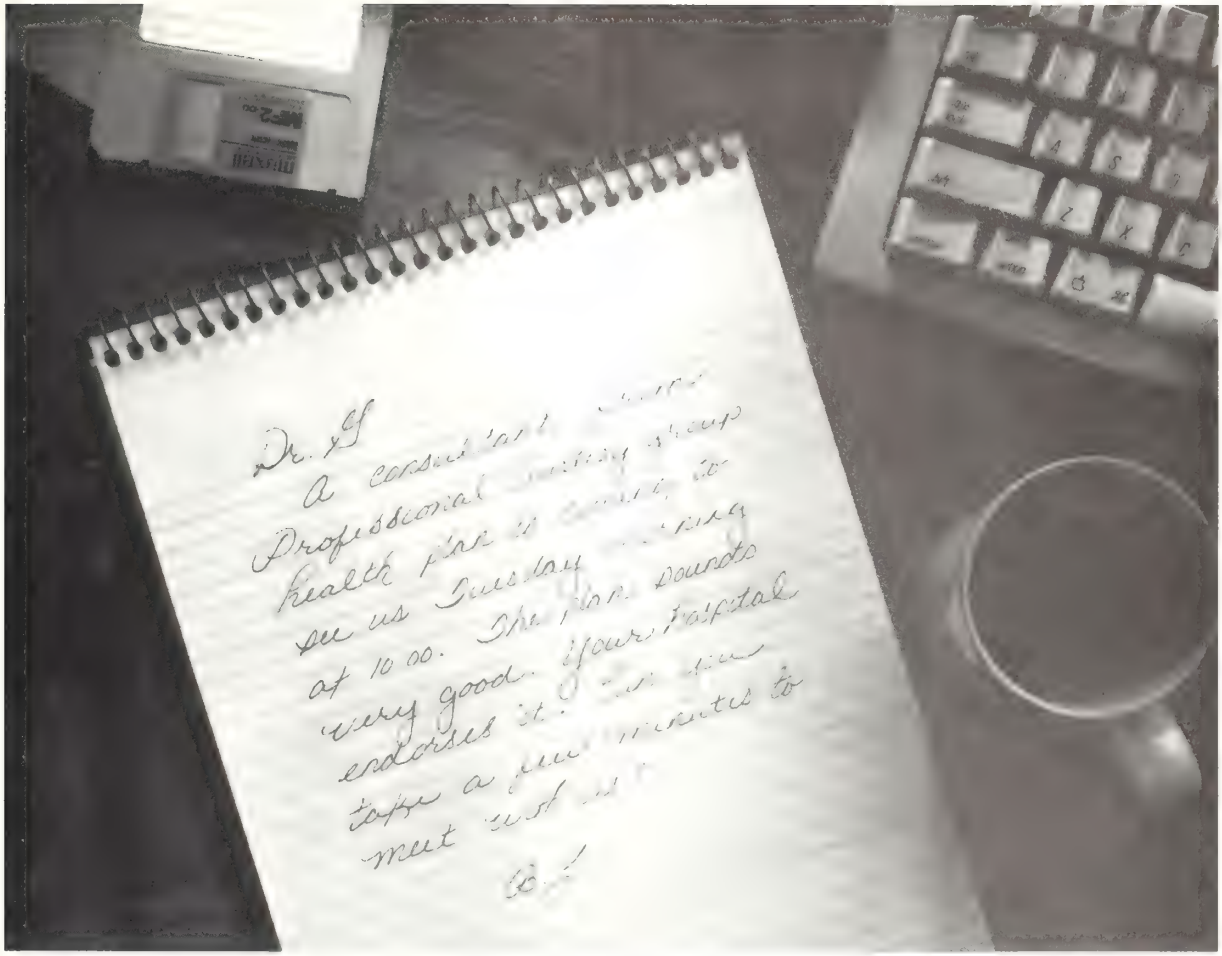
George Rawls, M.D., right, an Indianapolis surgeon, and his wife Lula discuss their views on health care legislation with Rep. Bill Crawford, D-Indianapolis, during Medicine Day. About 75 physicians and their spouses attended the event, which included breakfast, a visit to the statehouse to meet with legislators and lunch with legislators.



John D. MacDougall, M.D., left, an Indianapolis surgeon, talks with Michael O. Mellinger, M.D., a LaGrange family physician, during the breakfast at the Hyatt Regency Hotel.



Sen. Rose Ann Antich, D-Merrillville, second from right, and Sen. Lonnie Randolph, D-East Chicago, right, meet constituents in a Statehouse hallway. Pictured from left are Lee H. Trachtenberg, M.D., a Munster ophthalmologist; Don Henry, M.D., a Munster obstetrician/gynecologist; and C. Dyke Egnatz, M.D., a Schererville family physician, and back to camera, Promila Paul, M.D., a Munster ophthalmologist.



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Physicians, legislators enjoy 'islands' reception



John M. Records, M.D., right, a Franklin family physician, and his wife, Pamela, talk with Indiana Lt. Gov. Frank O'Bannon during the Jan. 27 ISMA Legislative Reception. Straw hats, sunglasses, maracas and a steel drum band helped set the mood for the "Escape to the Islands" theme.



Roy Kingma, M.D., right, a Demotte family physician, and his wife, Sonya, talk with Rep. Walter Roorda, R-Demotte. More than 300 people, including state legislators and ISMA members, attended the event at the Westin Hotel.



Clarence Clarkson, M.D., left, and James Daggy, M.D., center, both Richmond family physicians, are pictured with Rep. Dick Bodiker, D-Richmond.



Arden Pletzer, M.D., center, Anderson, a specialist in physical medicine and rehabilitation, and her husband, David Pletzer, M.D., a Fishers family physician, join Rep. Kathy Richardson, R-Noblesville, to discuss health care legislation.

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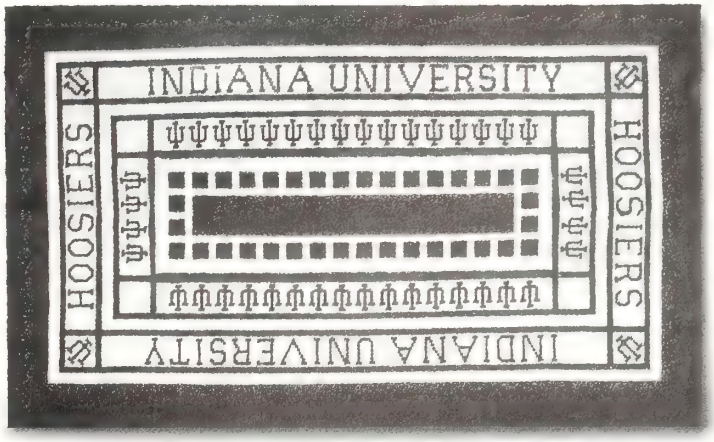
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Doctor keeps trains running in Aurora

Tina Sims
Managing Editor

Gordon Fessler, M.D., has been working on the railroad for 40 years, but every day is still a new adventure for the Aurora, Ind., family physician.

Dr. Fessler is a model train hobbyist who created literally from scratch a railroad display in his hilltop home that draws visitors from all over the world. "I've been a do-it-yourselfer for a great number of years," says Dr. Fessler, who will tackle almost any project, big or small. To accommodate his train layout, he added a 35 x 50-foot room to his house 14 years ago and invented and built a device that raised the 12-foot, 125-pound lengths of plasterboard used in the construction to an upright position. The contractor on the project told Dr. Fessler that his invention was so efficient that it put three men out of work for a week.

Although he started out initially to collect Lionel trains for his son, who was then about 7, he eventually discovered O scale trains in the 1950s and has "been working at it ever since." He estimates his collection now includes about 400 freight cars and 300 passenger cars.

Those cars run on a pike – as the train layout is called – that Dr. Fessler began 11 years ago to replace his first pike, which he knew could be improved. "I learned all the mistakes I ever made in the first pike," he said. He is not daunted by the amount of planning or labor involved in such an undertaking. "If the idea strikes, I do it," he says.

One such idea was the carpeting of his train room – after the pike was completed. He decided to carpet his room after visiting a model train layout in a carpeted room in Nashville, Tenn. The fact that his pike was already set up did not deter him; it was "just another challenge," he says. After buying the carpet from a Cincinnati hotel that was undergoing remodeling, three men spent three days installing the carpet while he operated the jacks to lift the tables.

He spent about six months planning the layout of his second pike. Utah copper mines, the Rocky Mountains, forests of the Northwest, West Virginia coal mines and the Indiana countryside form scenic backdrops for the trains. There are also Old West towns, grain elevators, lumberyards, an oil refinery, an amusement park and modern cities.

"I see where I can make improvements, but overall I like the plan," Dr. Fessler says of his second pike.

Photomurals on two adjacent walls give the layout an added dimension and offer visitors a view of the horizon. The murals, like almost everything else in his "little world," reflect Dr. Fessler's creativity. He took the photographs in black and white, had them enlarged, hung them and painted them in the colors of summer in Indiana. The rural scene depicts Indiana 262 from Rising Sun to Dillsboro, and although the city scenes were taken in both Memphis and Cincinnati, Dr. Fessler prefers to think of the city in his layout as Cincinnati.

Dr. Fessler's attention to detail is in evidence everywhere. Owls hide in trees, lamps decorate the miniature tables inside passenger cars and climbers with appropriate gear scale the slopes of mountains. A man peers through binoculars to get a better view of girls sunbathing atop a hotel. Because all hotels of the Wild West era reportedly had "red light" services, he couldn't resist positioning a nude woman in one window of the hotel. The only trouble, Dr. Fessler says, was finding such a miniature. When he couldn't find one, he made it himself.

Similarly, when he couldn't find a figurine who could pose as a cook calling cowboys to dinner, he painted a white apron on a male figurine and fashioned a miniature cast iron skillet, made from brass and painted black, for the figurine to hold.

Dr. Fessler is completing work on a steamboat, complete with lights and moving paddlewheel. But the boat needs a calliope, he says, so he's building one of wood and brass. Calliope music is already in place .

Calliope music isn't the only sound you'll hear in Dr. Fessler's train room. He has installed an audio system that also features train whistles, steam engines and rain and thunder. Other special effects include lightning accompanying the thunderstorm, a rainbow coloring the horizon after the storm and smoke spewing from the trash burner at the lumber yard.

Dr. Fessler has tried to give the Miami Road, as he calls his rail line, as much realism as pos-



Gordon Fessler, M.D., arranges some of the equipment in his large O scale train display. In addition to trains, his room includes a collection of train lanterns and a gate sign from Track 8 at Union Station in Cincinnati.

sible. During his travels around the country, he takes photos of sights he would like to include in his train layout so that his scaled-down replica will look as accurate as possible. "I don't build anything without pictures," he says. "Otherwise your imagination destroys your authenticity."

Although photographs help achieve this authenticity, so does a close-up visit to the site. He built his cement silo after visiting the Riverside silo near Cincinnati and receiving permission to ride the elevator for a look at the top of the structure. When he showed his finished replica to officials of the Riverside silo, they were so impressed they wanted to buy it, but Dr. Fessler politely told them it wasn't for sale. "I never considered myself a commercial builder," he says.

Besides, he was ready to move on to another project. "I work on what appeals to me at the time," Dr. Fessler says. "That way it won't get monotonous."

In addition to using photographs to achieve a realistic effect, he may also bring back touches of nature from vacations to match as closely as possible the color of the landscape. He returned from a trip to Utah with a soil sample so that he could duplicate the rust tones in his copper mine display.

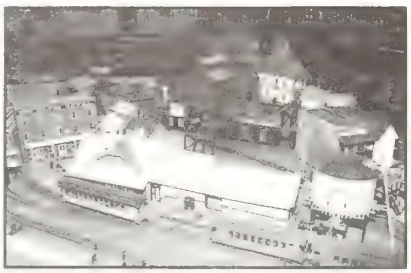
Animation adds to the realism. Tiny ice skaters gliding across a pond, steam shovels hauling dirt, and oil wells boring through the earth are among the moving parts dotting the landscape.

National attention and many friendships have resulted from Dr. Fessler's hobby. He was the subject of an article in the December 1990 issue of *Model Railroader,* which has a circulation of more than 200,000, and is scheduled to be featured in an upcoming issue of another model railroad magazine, *O Scale News. American Medical News* and *The Cincinnati Enquirer* also have published stories about him.

Through attendance at model railroad conventions, Dr. Fessler and his wife, Ruth Ann, have made many friends. The Fesslers say they know railroad buffs throughout the country and don't hesitate to call them if they're in the area. Likewise, the Fesslers have escorted many visitors through their train display, including a few people from Europe who wanted a tour after reading about Dr. Fessler in *Model Railroader.*

Dr. Fessler says model railroading appeals to so many people because "they want to duplicate the things they grew up with." He remembers his fascination with a steam locomotive "huffing and puffing" at the train station he walked past on his way home from high school. "It almost seemed alive," he says.

Future projects include building a landing for the riverboat and simulating a forest fire. And if he should ever win the lottery, he says, enlarging the train room would be just the ticket. ❑



Trains pass through many settings, such as this town in the Wild West.

Brain biopsy in Indiana AIDS patients

Fred Michael, M.D.
Scott Shapiro, M.D.
Julius Goodman, M.D.
David Hall, M.D.
Indianapolis

Abstract

The neuropathologic findings of brain biopsies in a series of Indiana AIDS patients were reviewed. All subjects displayed focal lesions on radiographic studies. The three most common diagnoses were toxoplasmosis, progressive multifocal leukoencephalopathy and primary central nervous symptoms (CNS) lymphoma. These findings were consistent with previous studies elsewhere. Biopsy appears to affect the course of treatment only if CNS lymphoma is discovered. Because the value of currently available therapy for this disease in AIDS patients is controversial, there is no clear consensus regarding the indications for biopsy in this population.

Forty percent of patients with acquired immunodeficiency syndrome (AIDS) will develop some form of central nervous system (CNS) symptoms.[1] Fifty-seven percent of all AIDS patients in an Indiana University study had abnormal findings on neuroimaging studies.[2] To study the role of brain biopsy in AIDS, the pathological findings were reviewed in a series of neurologically symptomatic patients who came to biopsy.

Previous studies have shown the three most common causes of focal cranial mass lesions in AIDS patients to be toxoplasmosis, primary CNS lymphoma and progressive multifocal leukoencephalopathy.[3] Rare cases of discrete mycotic or mycobacterial cerebral abscesses have been reported, mainly in populations of intravenous drug abusers.[4]

Although there are "classic" radiologic presentations for each of the three major causes of focal brain lesions found in AIDS patients, there are no truly pathognomonic presentations. Instead, the three are frequently indistinguishable by computed tomography (CT) or magnetic resonance imaging (MRI) in this population. It is because of this lack of diagnostic certainty that biopsy usually is performed. A review of radiologic features of brain lesions in AIDS patients may be found in the July 1991 issue of INDIANA MEDICINE.[3]

Of the three common mass lesion etiologies, toxoplasmosis is the most responsive to treatment. Symptomatic and radiographic improvement often is seen within weeks of antibiotic treatment onset.[5] The common practice of many clinicians is to treat empirically for toxoplasmosis in this situation and watch for improvement. When therapy is successful, maintenance therapy must be continued for life.

Progressive multifocal leukoencephalopathy (PML) is a demyelinating disease caused by the papovavirus JC. There is no treatment for PML, and survival is seldom more than weeks to months after the diagnosis is made.

Primary CNS lymphoma was an extremely rare entity before the advent of AIDS.[6] In a 1990 San Francisco study, 30% of all biopsied brain lesions in AIDS patients were shown to be CNS lymphoma.[3]

Radiation therapy is known to prolong survival time significantly in non-AIDS related primary CNS lymphoma. The benefit of radiation in AIDS patients, however, is less clear and will be addressed in this article.

Methods

A retrospective study of neuropathological findings in 28 AIDS patients was performed. All were neurologically symptomatic and displayed focal neuroradiologic findings. Each of the 28 underwent stereotactic brain biopsy, guided either by CT or MRI. The biopsies were performed between 1987 and 1991 at Methodist Hospital of Indiana and Indiana University Hospital in Indianapolis. All known biopsied patients

were included in the study.

Results

Four (14%) of the patients were first diagnosed with AIDS upon presenting with neurologic symptoms; the rest were previously known to be HIV positive. Twenty-seven of the 28 (96%) were men, with age ranges from 22 to 44 years (mean 34.3 years). *Table 1* lists presenting neurologic signs by the number of patients with each finding.

Ten patients (36%) were diagnosed with PML. Two died at one month, and one died at two months after biopsy. Because no surgical or medical interventions are available for PML, the remaining patients were lost to follow-up at home or in a nursing facility.

Eight patients (29%) had findings consistent with toxoplasmosis.

One patient was diagnosed with an embolic infarction. Another was given no diagnosis, as only a nonspecific necrotizing process was observed on pathological examination. One brain mass was found to be a pneumocystis abscess; cultures grew the pneumocystis and also propionibacterium acnes. One biopsy was read as normal.

Six patients (21%) were found to have primary CNS lymphoma. Of these, three began a course of radiation therapy: One completed the course but died 38 days after biopsy; one died four days after biopsy without completing therapy; and a third chose to undergo therapy at an outside hospital and was lost to follow-up. The remaining three patients received no radiation therapy: One died nine days after biopsy, and the other two were lost to follow-up.

Radiographically, most (21 of 28) of the brain lesions were supratentorial. By diagnosis, four of six primary CNS lymphomas showed lesions only above the tentorium, while seven of 10 PML cases, seven of eight toxoplasmosis cases and three of four other diagnoses were located supratentorially.

Nineteen of 28 patients had multiple brain lesions. Four of six CNS lymphomas, eight of 10 PML cases, five of eight toxoplasmosis cases and two of four other diagnoses displayed more than one lesion on MRI or CT. *Table 2* shows the breakdown by lesion diagnosis, location and number.

Two patients had complications after their stereotactic biopsies, one being a nonfatal hemorrhage at the biopsy site and the other a postoperative seizure. No deaths were related to the procedure itself.

Discussion

The types of neurologic pathologies seen in this series of AIDS patients in Indiana do not differ from those seen in previous studies elsewhere. Toxoplasmosis, PML and primary CNS lymphoma were all demonstrated. Histoplasmosis, known to be common in Indiana, was not seen in CNS lesions.

Although toxoplasmosis was found in 50% of all biopsied lesions in one study,[3] such cases probably were underrepresented in this series because of the practice of initiating empiric therapy at the time cranial lesions consistent with toxoplasmosis are discovered on brain scan. Many such cases presumably would have shown lesion regression with the therapy, thus obviating the need for biopsy.

A diagnosis of PML, seen in

Table 1

Neurologic presentation of AIDS patients with CNS lesions

Sign/symptom	Number of patients *
Mental status changes	8
Hemiparesis/weakness	8
Seizures	7
Headache	6
Cerebellar signs	3
Fever	2
Numbness/tingling	2
Normal exam	1
Not specified	3

* n = 28. Ten patients demonstrated multiple neurologic signs/symptoms at presentation.

more than one-third of the patients studied, offers little hope at present. Treatment is directed at providing patient comfort.

The small number of primary CNS lymphoma patients in this series precludes a statistically significant analysis of survival time. It is clear, however, that the prognosis is grim. Because the efficacy of therapy for CNS lymphoma is central to the issue of brain biopsy in these patients, a discussion of outcome studies for radiation therapy is warranted.

Primary CNS lymphoma therapy and biopsy indications

Biopsy is useful for differentiating between the often similar-appearing lesions of toxoplasmosis, primary CNS lymphoma and PML. Demonstrating toxoplasmosis will have little effect on the course of therapy if empiric treatment already has begun. A finding of PML is of diagnostic value only, as there is no treatment. Biopsy can then be indicated only if an effective treatment is available for CNS lymphoma.

Proponents of aggressive biopsy and irradiation argue that timely diagnosis and radiation therapy result in extended survival time. The early proponents based their recommendations upon old studies in non-AIDS patients.[7] Several findings since the advent of AIDS make such studies appear less applicable to AIDS-related lymphomas. The histologic grades of intracranial lymphomas in AIDS patients tend to be high-grade in virtually all cases.[8] Survival and radiographic response to radiation are significantly greater in non-AIDS related primary CNS lymphoma.[9]

The most positive review, in which the authors endorse early biopsy and irradiation, demonstrated tumor regression radiographically in most patients. The mean survival time in this study was 4.5 months,[8] compared to 2.2 months in another recent study.[9] However, the former represents survival time from the onset of symptoms consistent with the lesion, while the latter is calculated from time of onset of therapy. Another confounding variable is the administration of corticosteroids to all patients in the group with longer survival; the positive role of steroids in survival was not addressed.

In those cases where brain masses have responded positively to radiation therapy, all patients have died of opportunistic systemic infections within a matter of weeks to months. Because of this inevitable demise, the prognosis for these patients remains dismal.

Because of the potential for some degree of tumor regression, it seems reasonable to offer biopsy to any patient in whom the diagnosis is strongly suspected. The

Table 2

Lesion number and location by diagnosis

Diagnosis	Number of solitary lesions	Number of multiple lesions
Primary CNS lymphoma	2	4
PML	2	8
Toxoplasmosis	3	5
Other	2	2

Diagnosis	Number of supratentorial	Number of infratentorial	Number of both
Primary CNS lymphoma	4	0	2
PML	7	1	2
Toxoplasmosis	7	1	0
Other	3	0	1

physician should provide a full disclosure of the expected outcome to the patient. Such patient involvement is obviously impossible in the case of a comatose or demented patient. The value of biopsy in these patients may be questionable because recovery from coma or dementia after irradiation has not been documented.

Conclusions

Brain biopsy findings in this series of Indiana AIDS patients were consistent with previous studies. Biopsy is useful to differentiate between the lesions of toxoplasmosis, progressive multifocal leukoencephalopathy and primary CNS lymphoma but will significantly affect the course of treatment only if lymphoma is discovered.

Radiation therapy does offer a modest increase in survival time for AIDS patients with primary CNS lymphoma. Those who advocate aggressive biopsy and therapy believe that future advances in the management of opportunistic infections will result in more substantial survival gains, perhaps even cure. Lacking such advances at present, prospective studies that clearly demonstrate an improvement in length and quality of survival will probably be necessary for wide acceptance of routine biopsy in these unfortunate patients. ❑

The authors are affiliated with the Indiana University School of Medicine. Dr. Michael is a resident in the Department of Surgery, Dr. Shapiro is assistant professor of neurosurgery, Dr. Goodman is clinical professor of neurosurgery, and Dr. Hall is clinical assistant professor of neurosurgery.

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References

1. Levy RM, Bredesen DE: Central nervous system dysfunction in acquired immunodeficiency syndrome. *J AIDS*, 1:41-64,1988.

2. Kaissar G, Edwards M, Smith R: Neuroimaging of AIDS. *Indiana Med*, 7:470-474, 1991.

3. Ciricillo SF, Rosenblum ML: Use of CT and MR imaging to distinguish intracranial lesions and to define the need for biopsy in AIDS patients. *J Neurosurg*, 73:720-724, 1990.

4. Bishburg E, Eng RHK, Slim J, et al: Brain lesions in patients with acquired immunodeficiency syndrome. *Arch Intern Med*, 149:941-943, 1989.

5. Pons VG, Jacobs RA, Hollander H: Nonviral infections of the central nervous system in patients with acquired immunodeficiency syndrome. In: Rosenblum ML, et al, eds. *AIDS and the Nervous System*. New York, NY: Raven Press; 1988:263-283.

6. Henry JM, Heffner RR, Dillard LB, et al: Primary malignant lymphomas of the central nervous system. *Cancer*, 34:1293-1302, 1974.

7. So YT, Choucair A, Davis RL, et al: Neoplasms of the central nervous system in acquired immunodeficiency syndrome. In: Rosenblum ML, et al, eds. *AIDS and the Nervous System*. New York, NY: Raven Press; 1988: 285-300.

8. Baumgartner JE, Rachlin JR, Beckstead JH, et al: Primary central nervous system lymphomas: natural history and response to radiation therapy in 55 patients with acquired immunodeficiency syndrome. *J Neurosurg*, 73:206-211, 1990.

9. DeWeese TL, Hazuka MB, Hommel DJ, et al: AIDS-related non-Hodgkin's lymphoma: The outcome and efficacy of radiation therapy. *J Rad Onc Biol Phys*, 20:803-808, 1991.

auxiliary report

Trudy Urgena
ISMA Auxiliary President

The medical profession faces many critical challenges this year, and how these challenges are met will determine the profession's status at the dawning of the 21st century.

In partnership with the auxiliary, physicians can double their resources to address the critical issues challenging the profession. Twice the talent, time and energy are available to advance the goals of medicine when physicians and the auxiliary work together addressing their shared concerns.

Recognizing its capability to effectively assist the medical profession, the auxiliary identified six goals during its strategic planning to facilitate this assistance:

1) Create a working partnership with the ISMA.

- Change the organization year to match that of the ISMA and hold an annual meeting in conjunction with the ISMA annual meeting. This will encourage increased attendance at both meetings and help strengthen the partnership.
- Use the partnership to encourage increased membership in both organizations. As spouses become involved in each organization, the organization can encourage them to urge their spouse to join the partner organization.
- Develop a program to increase image with the county medical societies and provide support through increased programs with them.
- Use the partnership to promote physicians and their needs.
- Through the partnership, continuously monitor health care issues and develop a program to inform both memberships of these issues and their impact on health care.
- Create a coalition with other health organizations to strengthen the position of health care in Indiana.

2) Provide support mechanisms for physicians and their families in all areas of their professional and personal lives.

- Develop support programs for the physician, spouse and children to educate and provide emotional assistance to all members of the medical family.
- Through the partnership with the ISMA, increase support for the ISMA Commission on Physician Assistance Program and promote spouse understanding, support and participation.
- Develop programs to provide avenues for physician spouses to share problems, develop trust and improve personal self-image.
- Conduct family retreats for physicians and their families.

3) Develop ongoing programs relating to common interests of physician spouses provided in convenient and useful formats. Programs will focus on health-related issues.

- Develop programs to educate the public about healthy lifestyles and preventive health care.
- Continue and expand the legislative advocacy program.
- Continue, strengthen and expand leadership training programs to all members.

4) Maintain and expand membership. Develop both quantity and quality membership through programs to increase effective membership.

- Encourage openness to all potential members. Special sensitivity should be addressed concerning international spouses, male spouses, employed spouses, student and resident spouses, and other potential members.
- Identify and communicate valued reasons for holding membership to current and potential members.
- Develop a recognition of reward for membership through programs and organization image.

5) Develop and maintain a positive image through a concentrated image program.

- Educate members about the impact of image and its many publics and the relationship of perception versus reality.
- Be a professional organization conducting efficient, educated business through volunteer membership.
- Develop and institute a plan for professional, frequent positive press at all levels of state and county activities.
- Promote recognition that the organization and physicians are members of the Indiana community and they make a difference in the community.
- Consider the use of professional public relations/marketing assistance. Research potential sources among the membership.

6) Align organizational structure to facilitate achievement of strategic planning goals and adapt the organization to the needs of the 21st century.

- Realign the executive committee to include an ISMA representative in recognition of the partnership.
- Align membership of state board of directors with the goals and action plans of the strategic

plan.

- Review the bylaws and rewrite them as necessary to comply and facilitate the goals and action plans of the strategic plan.
- Improve communication throughout the organization.
- Conduct seminars and workshops in locations throughout the state on a rotational basis to facilitate membership and county participation.

In addition to these six goals of the strategic plan, the ISMA Auxiliary Board of Directors recommends changing the name to the ISMA Alliance. This recommendation will be voted on at the annual convention during the House of Delegates in April.

The new mission statement reads: "The mission of the Indiana State Medical Association Alliance is to serve the needs of medical families; to serve the membership through a strong federation; to work in partnership with the medical profession and other organizations; and to support and promote quality health care for the citizens of Indiana."

J. Thomas Morrical of Crowe Chizek Health Group assisted with the strategic planning process.

Annual convention

The annual convention will be April 21 through 23 at the Days Inn Recreational Atrium in Marion. Special guests will include James Todd, M.D., AMA executive vice president, and Esther Jansing, AMA Auxiliary health promotion chairman.

In celebration of the cultural diversity of physicians and their spouses, "World Tour" will be the convention theme. Different countries and cultures will be highlighted through ethnic foods, music, dress and customs.

Seminars slated during the convention include "Strategic Planning for the Medical Family," "Managing Conflict: How to Turn it into Opportunity," "Medical Family Financial Planning Strategies" and "Family Violence Prevention." Current county presidents and former state presidents will be honored.

All physicians and their spouses are invited to participate in the "World Tour" during the Auxiliary Annual Convention. ❑

Look-alike and sound-alike drug names

	ETRETINATE	ETIDRONATE
Category:	Antipsoriatic	Paget's disease
Brand name:	Tegison, Roche	Didronel, Norwich Eaton
Generic name:	Etretinate	Etidronate disodium
Dosage forms:	Capsules	Tablets
	LODINE	**CODEINE**
Category:	Nonsteroidal anti-inflammatory drug	Analgesic
Brand name:	Lodine, Wyeth-Ayerst	Codeine (various)
Generic name:	Etodolac	Codeine
Dosage forms:	Capsules	Tablets, injection, oral solution

Benjamin Teplitsky, R. Ph.
Brooklyn, N.Y.

Look-alike and sound-alike drug names can be misinterpreted by a nurse reading doctors' orders or by a pharmacist compounding physicians' prescriptions.

Such misunderstandings can result in the administration of a drug not intended by the prescriber. Awareness of such look-alike and sound-alike drug names can reduce potential errors. ❑

1992 Indiana State Medical Association membership report as of Dec. 31, 1992

	Active	Resident	Dues Exempt	Total
Adams	12	0	2	14
Bartholomew/Brown	92	1	18	111
Benton	1	0	1	2
Boone	17	1	10	28
Carroll	10	0	1	11
Cass	35	0	11	46
Clark	84	0	12	96
Clay	8	0	4	12
Clinton	14	0	4	18
Daviess/Martin	12	0	10	22
Dearborn/Ohio	30	1	3	34
Decatur	9	0	4	13
DeKalb	15	0	3	18
Delaware/Blackford	152	2	32	186
Dubois	38	1	4	43
Elkhart	133	0	36	169
Fayette/Franklin	21	0	4	25
Floyd	73	1	15	89
Fort Wayne/Allen	443	37	97	577
Fountain/Warren	7	0	3	10
Fulton	6	1	0	7
Gibson	10	0	4	14
Grant	65	1	24	90
Greene	12	0	5	17
Hamilton	55	1	6	62
Hancock	30	1	5	36
Harrison/Crawford	14	0	1	15
Hendricks	45	1	7	53
Henry	23	0	10	33
Howard	101	0	24	125
Huntington	14	0	7	21
Indpls./Marion	1,566	57	295	1,918
Jackson	22	0	6	28
Jennings	3	0	1	4
Jasper/Newton	12	0	4	16
Jay	10	0	6	16
Jefferson/Switzerland	29	0	9	38
Johnson	48	0	8	56
Knox	55	0	11	66
Kosciusko	27	1	4	32
LaGrange	11	1	3	15
Lake	603	2	114	719
LaPorte	105	0	25	130
Lawrence	41	0	7	48
Madison	126	2	33	161
Marshall	17	0	6	23
Miami	14	0	3	17
Montgomery	30	2	8	40
Morgan	28	0	5	33
Noble	15	0	2	17
Orange	4	0	2	6
Owen/Monroe	163	0	20	183
Perry	5	0	1	6
Pike	1	0	0	1
Porter	119	0	17	136
Posey	2	0	1	3
Pulaski	6	0	1	7
Putnam	13	1	4	18
Randolph	5	0	4	9
Ripley	11	1	0	12
St. Joseph	287	4	86	377
Scott	8	0	1	9
Shelby/Rush	26	0	6	32
Spencer	0	0	0	0
Starke	7	0	3	10
Steuben	10	0	6	16
Sullivan	5	0	4	9
Tippecanoe	177	1	41	219
Tipton	5	0	4	9
Vanderburgh	367	2	81	450
Vigo/Parke/Vermillion	141	1	34	176
Wabash	22	0	7	29
Warrick	16	0	0	16
Washington	8	0	1	9
Wayne/Union	88	0	25	113
Wells	43	0	15	58
White	4	0	5	9
Whitley	5	0	5	10
RMS	0	103	0	103
1992 totals	5,891	227	1,291	7,409
1991 totals	5,640	242	1,223	7,238

Membership information

	Active members	Chg from prior yr. active members:	Chg from prior yr. dues exempt mbrs:	Total:
1992	6,118	+ 103	1,291 (+68)	7,409
1991	6,015	- 72	1,223 (+106)	7,238
1990	6,087	+ 68	1,117 (+29)	7,204
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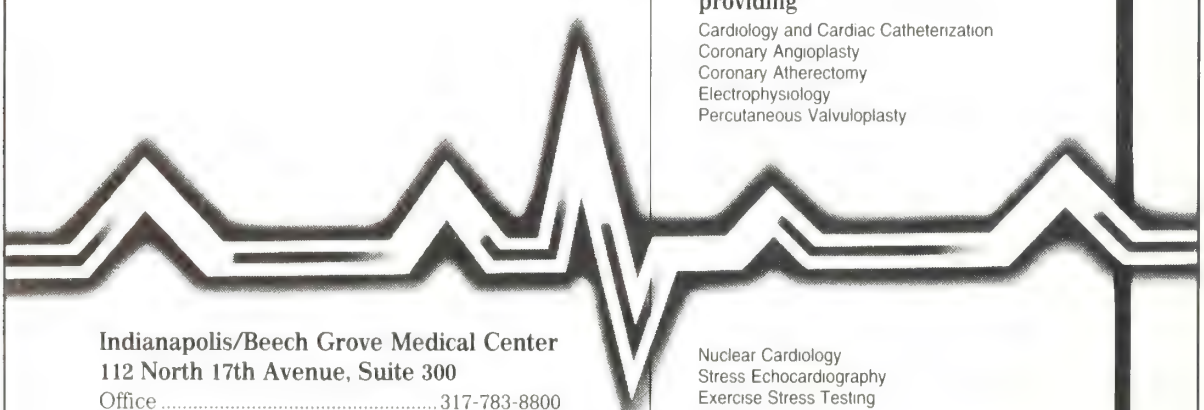
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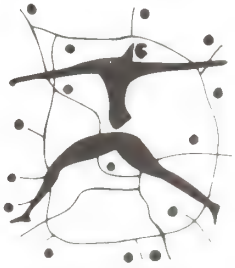
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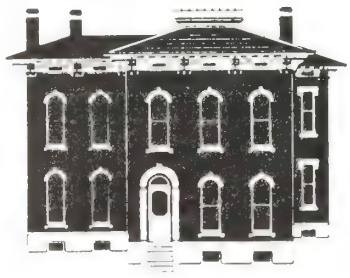


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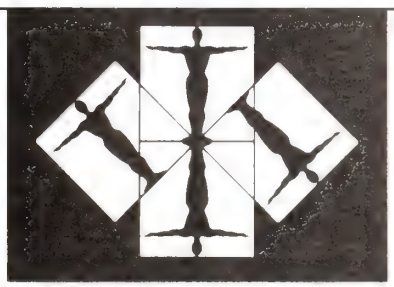
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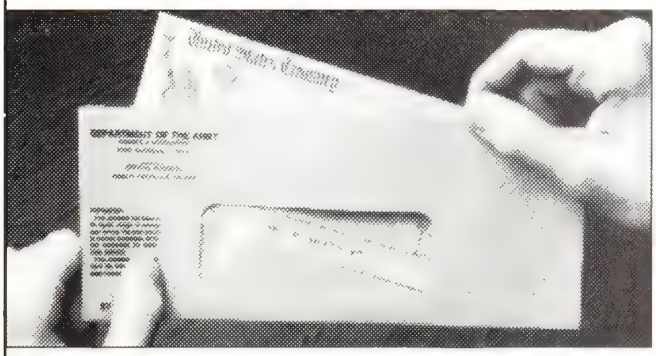
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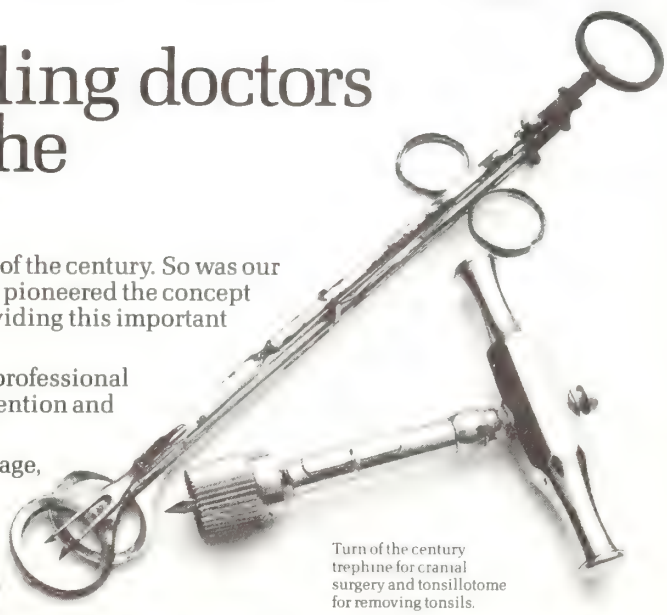
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from the museum

Dentists in America contributed to the discovery of anesthesia during the early 1800s. Despite the unresolved dispute that exists about its origins, this discovery greatly impacted the practice of dentistry and medicine.

As early as 1831, people knew about the existence of nitrous oxide gas, ether and chloroform. Yet, medical applications of the pain-relieving properties of these anesthetic agents did not occur until the 1840s.

The dentist Horace Wells (1815-1848) first observed the pain-relieving properties of nitrous oxide gas in 1844, when he attended a public demonstration showing the pleasant effects of inhaling nitrous oxide gas. Understanding the implications of these properties, Wells conducted further tests with himself and his dental patients.

In January 1845, Wells scheduled a demonstration of his discovery at Massachusetts General Hospital in Boston. However, the demonstration did not succeed because Wells stopped administering the gas too soon, and the patient cried out in pain.

Although medical practitioners did not accept the discovery, Wells continued to use nitrous oxide gas during extractions. He also discussed his results with other dentists, including William T.G. Morton (1819-1868).

At the suggestion of the chemist Charles T. Jackson (1805-1880), Morton began to explore the ability of ether to cause unconsciousness. On Oct. 16, 1846, Morton successfully demonstrated the pain-relieving properties of ether at Massachusetts General Hospital.

The discovery of anesthesia greatly affected the practice of dentistry and medicine. Both dentists and physicians began searching for more effective substances to relieve pain, and physicians began to expand the types of surgical procedures that this new discovery made possible.

Like dentists, physicians also devised many innovations to improve inhalers and other devices to administer anesthesia. Yet, throughout the middle 1800s, physicians preferred to use devices that allowed patients to determine the amounts of anesthesia they received.

In one method commonly used to administer anesthesia, a patient held an ether drop bottle in one hand and an ether-soaked sponge or handkerchief in the other hand. By reapplying ether to the handkerchief, the patient could maintain some control over the level of unconsciousness.

By the late 1800s, however, physicians began to use inhalers that allowed physicians to determine the amounts of anesthesia. In 1874, the physician Oscar H. Allis (1833 to 1921) had introduced an open inhaler that reduced the carbon-monoxide contamination that often occurred with the earlier inhalers that possessed closed designs.

The Indiana Medical History Museum in Indianapolis currently explores the discovery of anesthesia and other contributions Americans made to dentistry in an exhibit titled "Americans in a New Age of Dentistry." For information, call (317) 635-7329. ❑

Sources: 1) Elisabeth Bennion: *Antique Dental Instruments,* (1986); 2) Malvin E. Ring, D.D.S.: *Dentistry: An Illustrated History,* (1985); and 3) Charles Truax: *The Mechanics of Surgery, (1899).*



This daguerreotype depicts the second demonstration of ether, conducted by dentist William T. G. Morton. Morton, dressed in a checkered waistcoat, stands at the head of the operating table.

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St. Vincent Hospital

St. Vincent Hospital of Indianapolis will sponsor "Hernia '93: Advances or Controversies, An International Perspective" May 24 through 27 at the Radisson Hotel in Indianapolis.

For more information, call (317) 841-7171.

Methodist Hospital

Methodist Hospital of Indiana in Indianapolis will sponsor these CME courses:

Mar. 26-27 – ATLS, Methodist Hospital, Indianapolis.

Apr. 30 – Cognitive Therapy for Anxiety Disorders, Omni North, Indianapolis.

May 12 – Toxicology, Adam's Mark Hotel, Indianapolis, in conjunction with the Indiana Chapter American College of Emergency Physicians.

May 14 – Gordon W. & Mae Batman Lecture Series, Petticrew Auditorium, Methodist Hospital, Indianapolis.

May 14-16 – Total Quality Management in Primary Care, Hyatt Regency, Indianapolis.

May 14-15 – Medicine & Political Controversies in Vascular Disease, Radisson Hotel, Indianapolis.

May 28 – 19th Annual Wishard Lecture, Methodist Hospital, Indianapolis.

June 11-13 – American Fertility Society, Methodist Hospital, Hyatt Regency, Indianapolis.

July 25-31 – Diabetes Mini Fellowship, Happy Hollow Camp for Children, Nashville, Ind.

For details, call (317) 929-3733 or 1-800-847-3370.

Indpls. Regional Heart Center

The Indianapolis Regional Heart Center at St. Francis in Beech Grove will sponsor these CME courses:

Apr. 8 – Cardiac Refresher Course: Non-invasive Cardiology.

Apr. 22 – Cardiac Refresher Course: Non-invasive Cardiology.

Apr. 28-29 – Cardiac Refresher Course: Cardiac Care.

For more information, call Brandon Roger (317) 783-2776.

Indiana University

The Indiana University School of Medicine will sponsor these courses:

Apr. 4-6 – 1993 Symposium on Breast Imaging, University Place Conference Center, Indianapolis.

Apr. 23 – 16th Annual Arthur B. Richter Conference in Child Psychiatry, University Place Conference Center, Indianapolis.

Apr. 30 – Advances in Urological Oncology, Myers Auditorium, IUPUI campus, Indianapolis.

May 14 – New Horizons in the Practice of Medicine, University Place Conference Center, Indianapolis.

May 19-20 – 28th Annual Indiana Multidisciplinary Child Care Conference, Omni North Hotel, Indianapolis.

May 20-22 – 1993 Contemporary Issues in Total Hip & Knee Replacement, University Place Conference Center, Indianapolis.

July 8-17 – 78th Annual Anatomy and Histopathology of the Head and Neck and Temporal Bone, IUPUI campus.

For more information, call (317) 274-8353.

I.U. Alumni Day

The Indiana University School of Medicine will offer a daylong CME course, "New Horizons in the Practice of Medicine," in conjunction with Alumni Day May 14. The program will be at the University Place Conference Center in Indianapolis.

Course titles include Newer Endoscopic Pancreatobiliary Therapies, Role of Cardiac Transplantation in Management of Patients with Cardiomyopathy: Results of Cardiac Transplantation, Active or Passive Euthanasia: Is There a Difference?, New Concepts in Neurological Surgery, Medical Health Care Reform in Indiana, The Limb Preservation Institute and Osteosarcoma, Alzheimer's Disease, Occupational Lung Disease in Indiana, Ethical Issues in Growth Hormone Treatment of Normal Children with Short Stature, and Munchausen Syndrome by Proxy: Bizarre Form of Child Abuse.

For more information on Alumni Day, call (317) 274-8828. For information on the CME program, call (317) 274-8353. ❑

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obituaries

Anthony S. Blazys, M.D.
Dr. Blazys, 33, a South Bend anesthesiologist, died Jan. 23, 1993.

He was a 1986 graduate of the American University of the Caribbean.

Dr. Blazys was affiliated with St. Joseph's Medical Center.

Harry Brandman, M.D.
Dr. Brandman, 88, Galesburg, Ill., died Nov. 18, 1992.

He was a 1930 graduate of Rush Medical College.

Dr. Brandman, a psychiatrist, was a member of the Lake County Medical Society.

James R. Brown, M.D.
Dr. Brown, 56, a Valparaiso urologist, died Dec. 14, 1992, at Porter Memorial Hospital.

He was a 1961 graduate of the Indiana University School of Medicine and a member of the U.S. Air Force Reserve.

Dr. Brown, a former president of the Porter County Medical Society, opened his practice in Valparaiso in 1967. He was a member of the A.B.U. Arabian Horse Club and was involved in many animal protection programs.

James L. Fuelling, M.D.
Dr. Fuelling, 79, a retired Marion ophthalmologist, died Nov. 29, 1992. He was a resident of Speedway at the time of his death.

He was a 1937 graduate of the Indiana University School of Medicine and a Navy veteran of World War II. He served in the Navy 20 years, retiring in 1960 with the rank of captain. He was awarded the Navy Cross for his role in the rescue of hundreds of men trapped below the deck of the aircraft carrier USS Franklin. He also received the Purple Heart.

Dr. Fuelling practiced ophthalmology in Marion for 15 years, retiring in 1977. He was a diplomate of the American Board of Ophthalmology and a fellow of the American Academy of Ophthalmology and Otolaryngology. He wrote the chapter on ophthalmology for the *Aero-Space Medicine* textbook.

Benjamin F. Grant, M.D.
Dr. Grant, 85, a retired Gary family physician, died Dec. 20, 1992, at St. Mary's Medical Center.

He was a 1942 graduate of the Howard University College of Medicine and served as a commander with the U.S. Navy in Camp Pendleton, Calif., from 1954 to 1956.

Dr. Grant served as president of the Muncie chapter of the National Association for the Advancement of Colored People and chairman of the life membership committee of the NAACP. He received the NAACP Ovington Award and the Dr. Dudley Turner Achievement Award from the National Medical Association and was inducted into the Gary Civil Rights Hall of Fame. He was also active in his church. Dr. Grant retired in 1988.

Joseph L. Haymond, M.D.
Dr. Haymond, 80, a retired Indianapolis pathologist and medical laboratory director, died Nov. 28, 1992.

He was a 1936 graduate of the Indiana University School of Medicine.

Dr. Haymond had been a pathologist and director of Thornton-Haymond-Costin Medical Laboratory for many years and was medical director for the Muncie Plasma Center for three years. He was a past president and secretary of the Indiana Association of Pathologists and was certified in pathological anatomy and clinical pathology by the American Board of Pathology. He was a member of the American Society of Clinical Pathologists, the International Academy of Pathology and the American Association of Blood Banks.

William M. Holland, M.D.
Dr. Holland, 57, an Indianapolis internist, died Jan. 2, 1993.

He was a 1961 graduate of the Indiana University School of Medicine.

Dr. Holland was with Meridian Medical Group for 25 years and also was medical director for Indianapolis Life Insurance Co. for 25 years. He had served as chairman of the annual Diabetes Detection Drive sponsored by the Indianapolis Diabetes Association. He was an ISMA alternate delegate.

David E. Jones, M.D.
Dr. Jones, 84, a retired Indianapolis otolaryngologist, died Dec. 18, 1992, at Summer Trace Retirement Community in Carmel.

He was a 1933 graduate of the Indiana University School of Medicine.

Dr. Jones was an otolaryngologist in downtown Indianapolis for 50 years, retiring in 1984. He was a member of the American Academy of Plastic Surgery and Reconstructive Surgery.

Frederick C. Poehler, M.D.
Dr. Poehler, 61, former Wabash County health officer, died Nov. 23, 1992, at Lutheran Hospital in Fort Wayne.

He was a 1959 graduate of the Indiana University School of Medicine and a U.S. Army veteran of the Korean War. He

graduated from the University of Notre Dame, where he played football under Coach E. Frank Leahy.

Before moving to Fort Wayne 3 1/2 years ago, he lived in LaFontaine for 25 years. He was Wabash County health officer from 1964 to 1990. He also was an emergency physician at Marion General Hospital, plant physician at CPC in Marion and medical director at Shangri-La Health Care Center in LaFontaine and Vernon Manor Children's Home. He had served as chief of staff at Marion General Hospital and secretary of the 11th District Medical Society. Dr. Poehler received the Indiana Jefferson Award for Distinguished Public Service.

Guy E. Ross, M.D.
Dr. Ross, 86, a retired Anderson pediatrician, died Jan. 21, 1993.

He was a 1933 graduate of the Indiana University School of Medicine.

Dr. Ross organized the Anderson Public School Health System and headed it more than 40 years. He introduced the first antibiotic drug ever used in Anderson and helped pioneer polio vaccinations in Madison County. At various times he was chairman of the pediatrics departments at Community and St. John's hospitals in Anderson. He retired in 1979.

William D. Snively Jr., M.D.
Dr. Snively, 81, a retired vice president of Bristol-Myers, died Dec. 7, 1992, at Holiday Health Center in Evansville.

He was a 1938 graduate of the Northwestern University School of Medicine and was a flight surgeon with the Marines during World War II.

Dr. Snively worked for Mead Johnson & Co., advancing to the position of executive vice president. He served on the company's board until the company was taken over by Bristol-Myers. In 1969 he retired as vice president, medical information. He held academic appointments at the University of Evansville, the University of Kentucky Community College in Henderson, the University of Alabama in Birmingham and the Indiana University School of Medicine. He was a member of the Governor's Commission on Medical Education in Indiana. Dr. Snively received the American Medical Association Billing's Gold Medal for Scientific Exhibit, the Distinguished Service Award of the American Medical Writers Association and the Ross Award for the American Academy of General Practice for the most significant scientific article published in *General Practice* in 1962. He served as a consulting editor for INDIANA MEDICINE for many years and was a fellow of the American Medical Writers Association. ❑

In memoriam: Herbert C. Khalouf, M.D.



Dr. Khalouf, 63, a Marion surgeon and board chairman of the Physicians Insurance Co. of Indiana, died Jan. 27, 1993, at Marion General Hospital.

He was a 1957 graduate of the University of Pittsburgh School of Medicine.

Dr. Khalouf served the ISMA as an AMA delegate, a trustee and chairman of the executive committee. He was PICI board chairman from May 1991 until the time of his death. He recently retired from the board of directors at Marion General Hospital, where he served as vice president of the board. He had been president of the medical staff and member or chairman of various hospital committees.

He was a fellow of the American College of Surgeons and was certified by the American Board of General Surgery. He retired in 1990 as a general surgeon with Marion Surgeons Inc.

Dr. Khalouf was a member of Rotary International and a Paul Harris Fellow of Rotary International. ❑

news briefs

Committee seeks Beering Award nominations

The selection committee for the Steven C. Beering Award for the Advancement of Biomedical Science is seeking nominations for the 1994 award. The award is presented annually by the Indiana University School of Medicine as a tribute to the former dean.

The award honors a person for internationally recognized contributions to the advancement of biomedical or clinical science. The recipient prepares and delivers one major lecture, which is open to the medical community. The award winner will receive a medal and $10,000.

Nominations should be accompanied by a summary statement emphasizing the most important academic accomplishments of the nominee and importance to biomedical or clinical science and listing reasons the person deserves the honor. A curriculum vitae and a list of key publications should be included.

Information should be sent to Linda B. Griffin, Office of the Dean, Indiana University School of Medicine, Fesler Hall 302, 1120 South Drive, Indianapolis, IN 46202-5114. Nominations should be received by April 16.

Campaign encourages screening mammograms

The Indiana State Department of Health, the Indiana Division of the American Cancer Society and local hospitals will conduct the "Mammograms for Mother's Day" campaign again this year. The campaign encourages women age 40 and older to have a screening mammogram.

All mammography facilities in Indiana are being urged to offer mammograms during May for $55. A limited number of free mammograms will be available at selected sites.

The American Cancer Society hotline, 1-800-ACS-2345, will provide a list of participating facilities. People can also call the number to receive a packet of materials, including a special Mother's Day card and an ACS brochure on breast health. The materials urge women to coordinate with their family physician in making appointments for the screening.

This year the campaign will feature a special emphasis on minorities. A National Cancer Institute Survey reports that black women older than 40 are less likely to have ever had a mammogram than white women.

Physicians interested in promoting this program can get information packets to distribute to their patients by calling Jennifer Ashworth at the health department, (317) 633-0109.

Orthopaedics Indianapolis opens new medical clinic

Orthopaedics Indianapolis has opened its new 21,500-square-foot medical facility at the Methodist Hospital Professional Building, 1801 N. Senate Blvd. The clinic increases the number of examination rooms, doubles the x-ray and casting capabilities and includes a physical therapy unit.

The practice employs more than 100 medical and health care specialists, including 18 physicians.

Computerized orders reduce patients' hospital bills

Patients' hospital bills were reduced when physicians used a new computerized order-writing system, according to a study by Indiana University School of Medicine researchers at the Regenstrief Institute for Health Care. The results of the study, which involved more than 5,000 patients and 150 doctors at Wishard Memorial Hospital in Indianapolis, were released in the Jan. 20 issue of the *Journal of the American Medical Association*.

The patients whose doctors used the new system were discharged almost a full day sooner, with medical bills nearly $900 lower than patients whose doctors used the paper hospital chart. The new system also improves the quality of care by warning doctors of potential drug interactions, patient allergies and expensive treatments.

Physicians using the system during the study had generally favorable opinions of the network of microcomputer workstations, located throughout Wishard Hospital. They could write orders for any patient without having to go to the ward to use a chart. The system prints orders and test requisition forms on the patient's ward and sends drug orders to the pharmacy.

Physician use of the system lowered Wishard patients' bills by more than $3 million in one year. William M. Tierney, M.D., I.U. professor of medicine and primary author of the *JAMA* report, attributes the savings to a reduction in time-consuming errors and physician awareness of the cost of patient tests and treatments. The system also discourages the use of expensive technology, suggesting less expensive substitutes when there are safe alternatives.

Doctors using the system took five extra minutes a day per patient to write orders but gained some of that time back in more efficient handling of information.

More than 60% of all doctors using the system believed it resulted in more accurate orders and felt that using the system made their work more interesting.

Library services offered to visually, physically handicapped

A free library service providing books and periodicals on discs and cassettes, large-print books and braille materials for visually impaired and physically handicapped people is available from the Special Services Division of the Indiana State Library in Indianapolis.

Anyone who is unable to read or handle standard printed materials as a result of temporary or permanent visual or physical limitations can receive the service. Qualifying people include those having visual handicaps such as cataracts, glaucoma or macular degeneration and those with physical handicaps such as paralysis, lack of muscle coordination or prolonged weakness.

For more information about the service, call the state library, (317) 232-3684 or 1-800-622-4970.

First PET scanner in Indiana in operation

The Indiana University Medical Center and Richard Roudebush VA Medical Center have announced the operation of the first positron emission tomography (PET) scanner in Indiana. The IU/VA scanner project already has one partner, Community Hospitals Indianapolis, which joined the project at the time of purchase in January 1991.

The PET scanner is housed at the University Hospital and Outpatient Center at the medical center.

"Through cooperative arrangements, we intend to make PET available to any physicians whose patients can benefit from this unique diagnostic tool," said Walter J. Daly, M.D., dean of the I.U. School of Medicine.



William H. Beeson, M.D., ISMA president, left, accepts a check for the ISMA Physician Assistance Program from Jack Basler, chairman of the board of the Indiana Hospital Association. The IHA presented a $50,000 grant to the program to help educate hospital administrators, attorneys, personnel and physicians about impairing conditions affecting physician. The money, allocated over a two-year period, will be used to instruct how to recognize, intervene and monitor an impaired physician.

Booklet offers guidelines on surviving cancer

Physicians may want to tell their patients who are diagnosed with cancer of the availability of a booklet providing guidelines on how to improve the chances of surviving cancer.

The booklet, the *Cancer Research Institute HelpBook*, tells cancer patients how to proceed in obtaining the best possible care. It also discusses how to tap into various support services and how to approach financial considerations.

The *HelpBook* is available from the Cancer Research Institute, 133 E. 58th St., New York, NY 10022, 1-800-99CANCER. ❑

Psychiatric center opens

The Indiana Psychiatric Consortium has announced the opening of its Tipton Counseling & Psychiatric Center, located on Route 4 in Doctor's Park. The center is the fifth office to be operated by the consortium. ❑

people

Dr. Maurice E. **Arregui** of Indianapolis was a speaker at the Second International Multispecialty Congress on Endosurgery in Maui, Hawaii; his topic was the role of ERCP in the era of laparoscopic cholecystectomy, laparoscopic transcystic common duct exploration, laparoscopic ultrasound and laparoscopic inguinal herniorrhaphy. Dr. Arregui, director of fellowship in laparoscopy, endoscopy and ultrasound at St. Vincent Hospital, also gave presentations at the Mid-Pacific Symposium on Laparoscopic and Endoscopic Surgery, held in Maui, Hawaii.

Dr. Gonzalo T. Chua, director of the radiology residency program at Methodist Hospital in Indianapolis, coordinated the preparation and presentation of the "Case of the Day" exhibit at the annual Radiological Society of North America meeting in Chicago. In addition to Dr. Chua, other hospital staff and residents involved in the projects and exhibit titles were: **Dr. Laura Dugan** and **Dr. Susan J. Meyer**, "Skeletal Manifestations of Acute Lymphoblastic Leukemia"; **Dr. Jack M. Drew** and **Dr. John A. Scott**, "Moyamoya Syndrome in a Child with Sickle Cell Anemia"; **Dr. Julia Hornback-Widman**, "Angiosarcoma of the Breast"; **Dr. Dean Maglinte**, "Enterolith in a Blind Pouch"; and **Dr. Stephen J. Jay**, "Pulmonary Complications of Metastatic Angiosarcoma."

Dr. John D. Pulcini of Evansville Plastic Surgical Associates was the main speaker at a seminar on "The Maturing Female" at St. Mary's Medical Center in Evansville.

Dr. Frederick Bigler of Elkhart was elected president of the Indiana Association of Public Health Physicians, and **Dr. Craig Moorman** of Franklin was elected secretary-treasurer. Directors are **Dr. Eugene Gillum**, Portland; **Dr. John Hinton**, College Corner, Ohio; and **Dr. Frederick Ridge**, Linton.

Dr. J. Douglas Graham of Indiana Heart Physicians at St. Francis Hospital in Beech Grove discussed cardiac risk factors at the Older Americans Conference sponsored by the Indiana Affiliate of the American Heart Association.

Dr. Thomas J. Lord, an Indianapolis cardiologist, has been named medical director of the new medical specialty unit at Integrated Health Services at Cambridge, a skilled nursing and rehabilitation center in Indianapolis.

Dr. C. Conrad Johnston Jr., professor of medicine at the Indiana University School of Medicine, was appointed to the National Advisory Council on Aging; the council reviews applications from scientists seeking support from the National Institute on Aging for

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

November 1992
Bradley, Mark W., Columbus
Burrell, Michael J., Muncie
Cahn, Peter H., Indianapolis
Carney, Peter M., Elkhart
Crebo, Alan R., Kokomo
Drake, James R., Anderson
Ellis, Robert F., Merrillville
Felker, Dean R., Greenfield
Gentile, Jonathan P., Fort Wayne
Goodell, Charles L., Muncie
Kaye, Robert C., Rensselaer
Kelly, George G., Munster
Lucena, Bernardo S., Crown Point
Maxam, Beverly T., Indianapolis
McClary, Charles W., Bloomingon
Miller, James R., Merrillville
Oni, Richard O., Gary
Servies, Herschell, Lebanon
Shelton, N. Philip, Vincennes
Stolz, Thomas J., Otterbein
Towannasut, Verapon, Merrillville

December 1992
Ahler, Kenneth J., Rensselaer
Alig, Vincent B., Indianapolis
Asuncion, Leyte B., Tennyson
Barrett, Warrick L., Indianapolis
Bockelman, Henry W., Evansville
Brantly, James M., Indianapolis
Brown, Michael R., Terre Haute
Byrne, Frank D., Fort Wayne
Clarkson, Clarence G., Richmond
Duncan, David M., Fortville
Ehsan, Mohsen, New Albany
Emkes, Bernard J., Indianapolis
Griggs, Elmo A., Martinsville
Haddad, Rolando I., Jeffersonville
Houck, Verlin T., Nappanee
Jeha, Mikhail F., Valparaiso
Long, Lloyd O., Chandler
Marnocha, Kenneth E., Indianapolis
Mc Aleavey, Patrick J., Indianapolis
Pairitz, Frank D., South Bend
Shuman, Robert M., Granger
Spence, William C., Bloomington
Stegemoller, Ronald K., Danville
Subhasiriwatana, M., Crown Point
Whiteman, Thomas S., Muncie

research and training programs.

Activities and accomplishments of physicians at Northside Cardiology in Indianapolis include the following: **Dr. Thomas Linnemeier** gave a poster presentation on "Rail-Type Systems Reduce Radiation Exposure and Procedure Time Compared to Over-the-Wire Coronary Angioplasty Systems" at the American Heart Association's 65th Scientific Session. Dr. Linnemeier and **Dr. Donald Rothbaum** wrote an article on "Intravascular Ultrasound Imaging Combined with Coronary Angioplasty" for *Lancet*. **Dr. Eric Prystowsky** was a moderator for a symposium during the Unusual Arrhythmia Conference at European Hospital in Rome, Italy. **Dr. Morton Tavel** wrote an article on "Specificity of Electrocardiographic Stress Test in Women Versus Men" for *The American Journal of Cardiology*. **Dr. Joe Noble** is the co-chairman of the 1994 American College of Cardiology sessions and is serving on the American College of Cardiology Extended Learning Board/ Committee.

Dr. Stephen W. Perkins, an Indianapolis facial plastic and reconstructive surgeon, moderated a panel discussion at the winter meeting of the American Academy of Facial Plastic and Reconstructive Surgery in Boca Raton, Fla. He also was a guest speaker at a meeting of the Georgia Society of Otolaryngology in Atlanta.

Dr. Thomas W. Marshall, a Columbus orthopaedic surgeon, was selected president of the American Fracture Association.

Dr. Lester A. Hart, a family physician, is the 1993 vice chief of staff at Tipton County Memorial Hospital.

Dr. Henry R. Shallenberger has retired as a family physician in Modoc, where he has practiced since 1938.

Dr. Robert L. Mather, a Lafayette ophthalmologist, retired Jan. 1, after practicing in the Lafayette area since 1948.

Dr. David J. Welsh, Batesville; **Dr. Edward P. Daetwyler**, Evansville; **Dr. Thomas W. Dumas** and **Dr. Gregory S. Schmitt**, Fort Wayne; **Dr. David E. Wilson** and **Dr. Samuel A. Harmon**, Noblesville; and **Dr. Thomas J. O'Connor**, Lafayette, were named fellows of the American College of Surgeons.

Dr. Neil R. Harris of Elkhart and **Dr. George M. Underwood** of Lafayette have become certified medical review officers by the American Association of Medical Review Officers.

Dr. Grace L. Walker, a Terre Haute family physician, was honored as a distinguished alumna of Vincennes University.

Dr. Stanton E. Cope has retired after 43 years as a Huntington family physician.

Dr. Herbert E. Ware of Muncie was named a fellow of the American Academy of Family Physicians.

Dr. Jose C. Torres, a Jeffersonville surgeon, was a guest speaker at the International Symposium on Obesity Surgery in Genoa, Italy; he spoke on gastric bypass distal roux-en-Y with variable limb lengths and common channel.

Dr. James A. Hall of Logansport discussed the management of abnormal mammography at the annual meeting of the Central Association of Obstetricians and Gynecologists in Chicago.

Dr. Andrew E. Moore, an Indianapolis urological surgeon, was elected to the Wishard Memorial Foundation board of directors.

Dr. Harley H. Frey Jr. of Lafayette received the 1992 Distinguished Service Award from the Indiana Society of Anesthesiologists.

Dr. Daniel Rains, New Castle family physician, was named president of the Henry County Memorial Hospital medical staff. Other officers are **Dr. Nancy Griffith**, a New Castle family physician, vice president, and **Dr. Mark Davisson**, a New Castle internist, secretary.

Dr. Randall L. Stevens, assistant director of the family practice clinic at Union Hospital in Terre Haute and medical director at Hamilton Center, received a Friends Award from the Wabash Valley Alcohol and Drug Associates. The award honors people for their "sincerity and caring in helping people with addictions."

Dr. Deborah I. Allen, head of the department of family medicine at the Indiana University School of Medicine, received the Thomas W. Johnson Award of the American Academy of Family Physicians. The award recognizes contributions to family practice education.

Dr. Kenneth E. Bobb of Seymour was recognized for 35 years of continued membership in the American Academy of Family Physicians.

Dr. Jerome H. Wait retired after 37 years as a Columbia City family physician; he will continue to work as an anesthesiologist at Whitley County Memorial Hospital.

Dr. Philip Ball, a Muncie internist, received the Indiana Laureate Award from the American College of Physicians (ACP). The award honors fellows of the

people

ACP who have demonstrated an abiding commitment to excellence in medical care, education or research and in service to their community and the ACP.

Dr. Shivaji A. Gunale, an Indianapolis oncologist, and **Dr. David A. Josephson**, an Indianapolis neurologist, were inducted into the Fellowship of Distinguished Physicians at Community Hospitals Indianapolis. ❑

New ISMA members

Jonathan H. Bevers, M.D., Columbus, psychiatry.

William Boeckmann, M.D., Decatur, anesthesiology.

Garland E. Byron, M.D., Lafayette, internal medicine.

Paul P. Chu, M.D., Muncie, anesthesiology.

Daniel M. Cooke, M.D., Granger, anesthesiology.

Daniel J. Daunhauer, M.D., Muncie, radiology.

Martha J. Dwenger, M.D., Columbus, diagnostic radiology.

Jose-Mari L. Elacion, M.D., Fort Wayne, family practice.

Daniel P. Elskens, M.D., Lafayette, neurological surgery.

Gary P. Erdy, M.D., Newburgh, family practice.

Douglas P. Ericson, M.D., Muncie, diagnostic radiology.

Gary M. Gaddis, M.D., Muncie, emergency medicine.

Inigo A. Garcia-Zozaya, M.D., Fort Wayne, family practice.

Robert J. Goulet, M.D., Indianapolis, general surgery.

Heather B. Gutwein, M.D., Sheridan, family practice.

Ashraf H. Hanna, M.D., Fort Wayne, family practice.

James A. Hayes, M.D., Richmond, internal medicine.

Anthony C. Henry, D.O., Columbia City, family practice.

Andreana L. Hodgini, M.D., Fort Wayne, family practice.

Robert F. Jackson, D.O., Marion, orthopaedic surgery.

William T. Jones, M.D., Indianapolis, urological surgery.

Ferydoon Khoshnejad, M.D., Union City, obstetrics and gynecology.

C. Kurtis Kim, M.D., South Bend, anatomic/clinical pathology.

Stephen H. Kimura, M.D., Elkhart, allergy and immunology.

Habib J. Komari, M.D., Indianapolis, internal medicine.

Keith E. Kucera, D.O., Marion, gastroenterology.

Bruce D. Love, M.D., Indianapolis, anesthesiology.

Kevin J. Luksus, M.D., Anderson, family practice.

Matthew J. Mick, M.D., Indianapolis, cardiovascular diseases.

Michael J. Miller, M.D., Lafayette, radiation oncology.

M.A. Karim Moshref, M.D., Fort Wayne, family practice.

Lee A. Muskovitz, M.D., Valparaiso, neonatal-perinatal medicine.

Ruth C. Osborne, M.D., Sheridan, family practice.

Kiranchandra M. Patel, M.D., Fort Wayne, family practice.

Pravinbhaiz Patel, M.D., Fort Wayne, family practice.

Nandan K. Puvvada, M.D., Bedford, general surgery.

Krishna M. Ragothaman, M.D., Fort Wayne, family practice.

John C. Ramsey, M.D., Indianapolis, urological surgery.

G.V. Subba Rao, M.D., Huntingburg, orthopaedic surgery.

Joseph Rosenblum, D.O., LaPorte, cardiovascular diseases.

Paul Schoon, M.D., Indianapolis, obstetrics and gynecology.

Phillip C. Scott, D.O., Richmond, family practice.

Scott M. Sharp, M.D., Indianapolis, cardiovascular diseases.

Harry D. Silsby, M.D., Lafayette, psychiatry.

Keith A. Singer, M.D., Indianapolis, general practice.

Indra Sriram, M.D., Fort Wayne, internal medicine.

Peter M. Voss, M.D., Muncie, obstetrics and gynecology.

Carol L. Weesner, M.D., Indianapolis, emergency medicine.

Residents

Vance M. Abshire, M.D., Indianapolis, internal medicine. ❑

INDIANA UNIVERSITY School of Medicine, Evansville Center, one of eight regional campuses of the Indiana University Statewide Medical Education System, seeks candidates for clinical program coordinator. A 0.5 FTE academic appointment, responsible to the center director for management of the required Introduction to Medicine course and works with other center faculty to emphasize relevant clinical correlations in the two-year basic science curriculum. Will work with local hospitals, recruit volunteer faculty from practicing area clinicians and assist them with educational approaches and the scope of material to be covered, which will emphasize primary care skills, e.g., physical diagnosis and interviewing techniques. M.D., board certification in a primary care discipline and significant practice experience required. May elect to conduct a part-time private practice. Send C.V. and three references to Rex D. Stith, Ph.D., Director, Evansville Center for Medical Education, P.O. Box 3287, Evansville, IN 47732. AA/EOE, M/F.

PEDIATRICIANS – Two busy pediatricians seeking BE/BC pediatricians to join their group to meet the growing needs of the community. Currently seeing more than 300 patients per week and turning away an additional 20 patients weekly. Will offer guaranteed first-year salary, paid malpractice, disability and medical insurance and more. Opportunity for partnership after one year. Practice is located in new office building only seven minutes between two 200+ bed hospitals. Community is growing, safe and friendly. County population is 83,000 with a service area of 196,000. The county has one of the highest effective buying income levels in the Midwest. For more information, contact John Radjeski, Kokomo Pediatrics, 2341 W. Lincoln Blvd., Kokomo, IN 46902, (317) 455-4080.

SIOUX CITY, IOWA – An excellent position is available for a BC/BE family practice physician in a new community health center. A full range of family practice medicine is needed in a community that is very supportive of the center. Sioux City is a great place to raise a family and has excellent public and parochial school systems, a community college, two liberal arts colleges, a graduate center, two excellent medical centers, a residency training program (family practice), etc. The center offers a competitive compensation and benefit package, paid malpractice, etc. For more information, write Jeff Hackett, Executive Director, Siouxland Community Health Center, 1709 Pierce St., Sioux City, IA 51105, or call (712) 252-2477.

REFURBISHED MEDICAL EQUIPMENT – Omega automatic blood pressure unit, new. Ritter Procto table. Portable x-ray. Shampaine ob-gyn table. Autoclaves. Infant and adult scales, color-coded, excellent condition. Lab centrifuges. Mixed bag of surgical drapes, towels, instrument wraps in 50 lb. boxes, $100. Microscopes, Olympus sigmoidoscope. Contact Bernard Medical Resources, 1555 Dixie Highway, Covington, KY 41011, 1-800-892-3716, fax: (606) 581-5205.

SUBURBAN COLUMBUS, OHIO – Another internist needed to join four others in a college town. Population 80,000 and expanding. Subspecialty and surgical back-up at modern hospital. Columbus and major university medical school 40 minutes away. Guarantee + office. Walter F. Smith, 1-800-221-4762.

EMERGENCY MEDICINE – GENERAL PRACTICE: Expanding emergency medicine-general practice contract group needs physician for central Indiana facility. Guaranteed salary and vacation. Contact John L. Earnest, Preferred Medical Management, P.O. Box 1897, Marion, IN 46952, (317) 668-1500.

FAMILY PRACTICE – A group of four physicians seeks two additional family practice physicians to join long-established group practice. Located in picturesque Middlebury, Ind., the group serves a large Amish population, with obstetrics being an important part of the practice. Middlebury is a progressive community near the University of Notre Dame in north central Indiana. A family community with excellent schools, unique shopping and great dining. Modern, well-equipped hospital facilities and quality support staff. Contact Rick Addis, Goshen General Hospital, 200 High Park Drive, Goshen, IN, 1-800-258-4321.

FAMILY PRACTICE – Two board-certified family practice physicians seek third family practice physician to replace retired physician. Long-established practice on Lake Wawasee, the largest natural lake in Indiana. Diverse practice includes adult and pediatric medicine, great payor mix and excellent income potential. Lake community offers skiing, sailing, fine dining, summer stock theatre and name entertainment. Excellent schools, safe, friendly small town community. Contact Rick Addis, Goshen General Hospital, 200 High Park Drive, Goshen, IN, 1-800-258-4321.

EMERGENCY MEDICINE – Southeastern Indiana/Greater Cincinnati. Full-time emergency medicine position available July 1993. Rural setting. 30-minute commute from Cincinnati. Be a part of a four-member team at a modern E.D. facility with 17,000 annual visits. Compensation 130K plus bonus and full benefits. Desire BC/

classifieds

BP in IM, EM, FP. ACLS/ATLS required. For more information, contact Jeff Kennedy or Steve Gunderson, M.D., at 1-800-676-5572.

WISCONSIN-MICHIGAN – What are your prerequisites for a practice? Strelcheck & Associates, an extension of our clients' recruiting departments, has several opportunities which might be of interest to you. We currently represent our clients in the areas of dermatology, emergency medicine, neurosurgery, occupational medicine, oncology, orthopedics, orthopedics-hand, otolaryngology, psychiatry and urology. Locations in metropolitan areas, mid-size cities, on lakes, streams or near forests – you choose. To discuss your practice preferences and these opportunities, please call our toll-free number, 1-800-243-4353, or send your CV to STRELCHECK & ASSOCIATES, INC., 10624 N. Port Washington Road, Mequon, WI 53092.

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FAMILY PRACTITIONERS/INTERNISTS-BC/BE – Saint John's Health Care Corporation, a member of the Holy Cross Health System, is a 371-bed facility in central Indiana. Saint John's was recognized by the JCAHO as a top 10% quality organization in the nation. Very competitive compensation and incentives are available to qualified physicians locating in the Saint John's service area. Anderson, Ind., is a pleasant 60,000-resident community close to Indianapolis with the advantages of a major metropolitan area. Send CV or contact Steven Pavik, Director, Medical Staff Affairs, Saint John's Health Care Corp., 2015 Jackson St., Anderson, IN 46016, (317) 646-8303.

$180K GUARANTEED: FPs/GPs earn great personal income and enjoy excellent call coverage. Benefit from major university within 20 minutes, two metro areas within 1 1/2 hours. Package includes attractive bonus, paid overheads and interview expenses. For more information, send your CV to Bill Cox of Harris Kovacs Alderman, 5420 Southern Ave. West, Suite 407, Indianapolis, IN 46241 or call 1-800-776-7901, ext. 2-024. You may also fax your CV to (317) 247-8533.

$130K GUARANTEED: All family practices in town are full and payer mix includes 75% insurance. Share 1:5 call in solo setting, associate with quality existing practice or work in satellite clinic. Beautiful lake nearby, three metro areas within one hour. Package includes paid overhead, bonuses and temporary housing. For more information, send your CV to Bill Cox of Harris Kovacs Alderman, 5420 Southern Ave. West, Suite 407, Indianapolis, IN 46241, or call 1-800-776-7901, ext. 0-0016. You may also fax your CV to (317) 247-8533.

FAMILY PHYSICIAN WANTED to join a two-physician group in west central Indiana. Salary negotiable. Call or write to Frank Swain, M.D., Parke Clinic, P.O. Box 185, Rockville, IN 47872, (317) 569-3182.

EMERGENCY CARE PHYSICIANS – Expanding emergency medicine group seeking career-minded physicians for multiple Indiana locations. Twenty-year history without a lost contract. Hourly compensation based on training, experience and qualifications. Excellent benefits include 401(k) pension plan; malpractice, health, life and disability insurance; CME allowance; and ACEP, ISMA and hospital dues. Will consider all physicians with emergency medicine experience and interest. Contact Jim Gardner, M.D., Director, Corporate Development, Emergency Care Physicians, 640 S. Walker St., Suite A, Bloomington, IN 47403, (812) 333-2731.

IMMEDIATE CARE PHYSICIANS – Expanding immediate care group seeks career-minded primary physicians for multiple Indianapolis locations. Corporation is physician-owned and operated with 11 years of experience in Indianapolis metropolitan area. Compensation based on training, experience and qualifications. Excellent benefits include 401(k) pension plan; malpractice, health, life and disability insurance; CME allowance; and ACEP, ISMA and county dues. Will consider all primary medical disciplines with interest in outpatient medicine. Full-time opportunities only. Contact Jim Gardner, M.D., Director, Corporate Development, Emergency Care Physicians, 640 S. Walker St., Suite A, Bloomington, IN 47403, (812) 333-2731.

PHYSICIAN PRACTICE OPPORTUNITIES – Statewide/nationwide/worldwide. All specialties, group/solo, varied income arrangements. Contact Larson & Trent Associates, Box 1, Sumner, IL 62466-0001. Telephone: (618) 936-2662, 936-2970 or (800) 352-6226.

FAMILY PRACTICE opportunities available in Fort Wayne, Ind. Practice setting extremely flexible. Solo

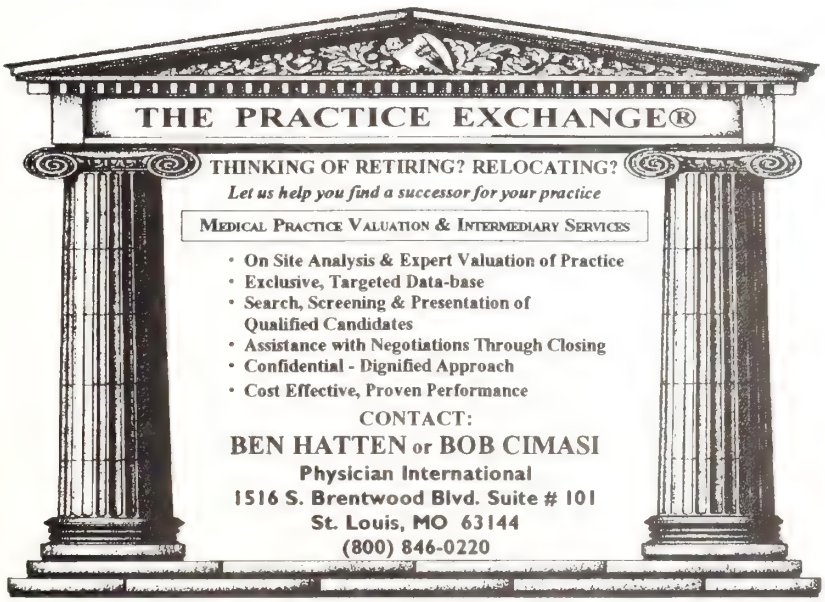
or group. Salary guarantee, relocation and other expenses paid. An opportunity to practice medicine and leave administrative and billing headaches to someone else. For complete details, contact our physician recruiting officer at (219) 489-2772, ext. 415.

MULTIPLE AND VARIED physician practice opportunities currently exist both within and outside Indiana. Call Patti Quiring at work, (317) 841-7575, or at home, (317) 823-4746. Patti is a physician recruiter for Quiring Associates, an executive search firm headquartered in Indianapolis.

GENERAL INTERNIST – BC/BE. To join a busy five-man practice with special interest in hospital intensive care, plus consultative and primary care practice in the Indianapolis area. Will offer partnership. Reply to Box 19616, Indianapolis, IN 46219.

EMERGENCY MEDICINE – Terre Haute, Ind. Local multi-hospital group seeking full-time career-oriented emergency physician for position in small- and medium-volume community hospitals. Flexible scheduling, very competitive compensation package, partnerships available. Send CV or contact William R. Grannen, Priority Health Care, P.C., 7179 Lamplite Ct., Cincinnati, OH 45244, (513) 231-0922.

CENTRAL INDIANA – Physician-owned emergency group accepting applications for full-time, career-oriented emergency physicians. Flexible work schedules and excellent benefit package. Part-time and directorship positions also available. Send CV or contact Midwest Medical Management, Inc., 3645 S. East St., Indianapolis, IN 46227-1240, (317) 783-7474. ❑



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CONTRAINDICATIONS

Hypersensitivity to any component of this medication

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of child-bearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin, the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine. The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* (1 hour prior to PRAVACHOL), *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chononic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chononic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Hardenan gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*; a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter²). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated, adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy, this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug.

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitounnary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma, anorexia, vomiting.

Reproductive. gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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Issued: September 1992

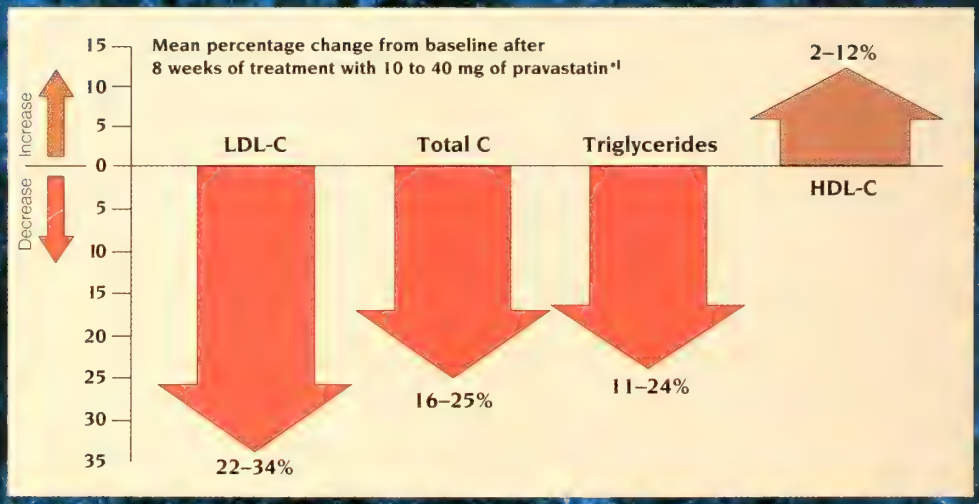
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Effective cholesterol control

Consistently and significantly reduces total C and atherogenic LDL-C; positively affects other key lipids



*Each arrow represents a range of means derived from a single placebo-controlled study that included 55 patients treated with pravastatin.

PRAVACHOL® (pravastatin sodium) is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

Active liver disease *or* unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin.

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia, a dose-response study. *Clin Cardiol*. 1991;14:146-151.

PRAVACHOL pravastatin sodium 20 mg tablets

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page

Bristol-Myers Squibb Company


INDIANA
MEDICINE
The Journal of the Indiana State Medical Association
May/June 1993
Vol. 86, No. 3
VOLUNTEER HEALTH CARE:
Serving the needy

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac

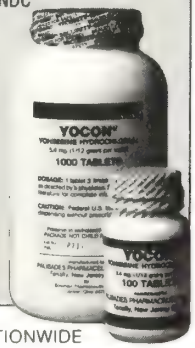
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Indiana physicians attend health care summit in Washington

Physicians representing the Indiana State Medical Association traveled to Washington, D.C., March 23 and 24 for the AMA-organized health care summit, "A Time for New Partnership." The physicians met with Indiana's representatives in Congress and heard speeches by top political leaders during the meeting, which was designed to give physicians a chance to voice their views on health system reform.

Indiana physicians who attended included: William Beeson, M.D., ISMA president, Indianapolis; S. Campbell Gabrielsen, M.D., Greenfield; Robert D. Glassman, M.D., Indianapolis; John A. Knote, M.D., Lafayette; Edward L. Langston, M.D., Noblesville; Glenn Loomis, M.D., Indianapolis; John D. MacDougall, M.D., Beech Grove; Michael Mellinger, M.D., LaGrange; John M. Records, M.D., Franklin; David Smith, M.D., Cumberland; Ronald Stegemoller, M.D., Danville; William C. VanNess II, M.D., Summitville; and Gerald C. Walthall, M.D., Indianapolis. Others attending were: Richard King and Susan Grant, from the ISMA staff, and physician spouses Marian G. Miller, Lafayette; Pamela Records, Franklin; and Trudy Urgena, Marion.

They met with Indiana congressional Reps. Jill Long, Lee Hamilton, Tim Roemer, John Myers, Frank McCloskey and Steve Buyer; with staff members from the offices of Reps. Dan Burton, Andy Jacobs and Phil Sharp; and with health assistants representing Sens. Dick Lugar and Dan Coats. Physicians heard presentations from Donna Shalala, secretary of Health and Human Services; Vice President Al Gore; and other political leaders.

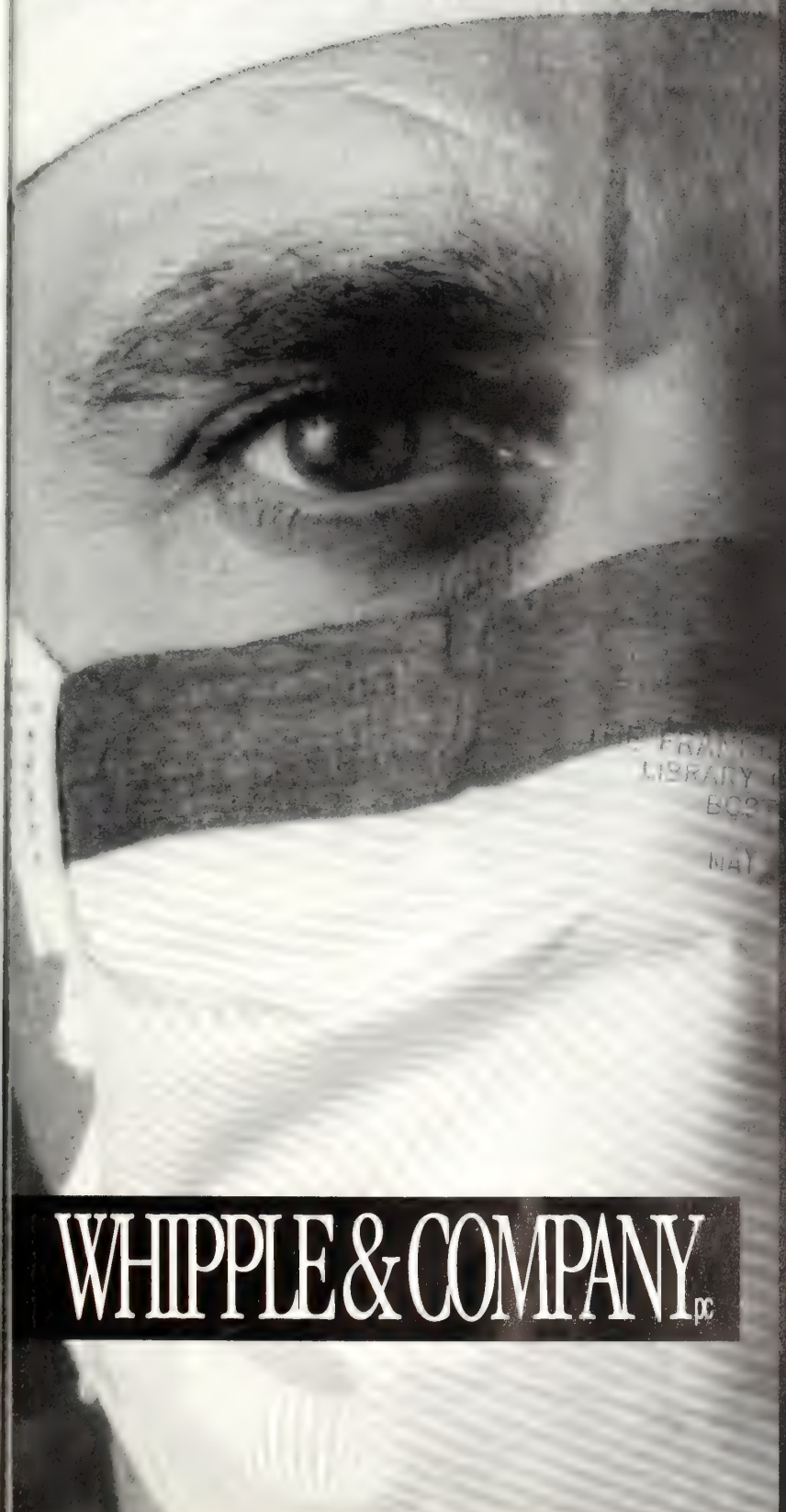
Dr. Mellinger said, "All agree there must be cost containment, but there is no agreement on how to accomplish it. Most seem to be leaning toward caps, a freeze or some type of global expenditure targets." He also observed that "doctors are not the only ones who expressed frustration at being left out of the decision-making process. Clearly, much of the Democratic congressional leadership feels excluded as well."

June 30 deadline for physicians to renew licenses

The Medical Licensing Board of Indiana has mailed renewal notices for license renewal fees due on June 30. There is no grace period this year.

Any physician who does not pay the renewal fee by the June 30 deadline must pay a $50 penalty in addition to the $50 renewal fee. The renewal fee for the Controlled Substance Registration (CSR) is $20 for each one issued; there is also a $20 penalty if not renewed by June 30. If you have moved since last receiving your renewal registration form, notify the Medical Licensing Board at (317) 232-2960. Failure to renew your license will render your license to practice medicine invalid. ❑

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letters to the editor

I have just finished reading the article by Bob Carlson titled "Medicaid rescue effort to be painful" in the March/April 1993 issue of INDIANA MEDICINE.

In the article, Mr. Verdier states that Indiana physicians are paid 118% of Medicare payments.

Let me tell what the reimbursements in my office are:

Code 99212	Medicare	$20.77 (down 12 cents from 1991)
	Medicaid	$19.50
Code 99213	Medicare	$27.89
	Medicaid	$20 (only one 99213 per month per patient or denied)

It may be that physicians who do procedural medicine are getting paid 118% of Medicare reimbursement, but physicians who do cognitive medicine probably are getting close to what I have detailed.

Why do we not have those who represent medicine questioning statements like Mr. Verdier's rather that accept what he says without comment?

We who are responsible physicians are willing to do our part, but health care providers should not bear the brunt of a poorly run program without our at least having the record straight. ❑

James Black, M.D.
Brownsburg

Dear Dr. Mellinger,

I enjoyed your editorial in INDIANA MEDICINE ["Health care reform should begin with insurance industry," March/April 1993], and I completely agree with your comments. My only worry is that physicians and not patients will read it. ❑

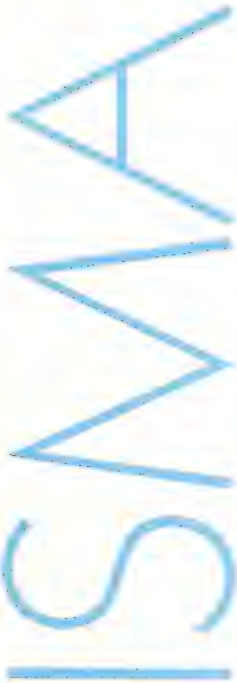
Clay L. Molstad, M.D.
Lafayette

Letters to the editor

INDIANA MEDICINE welcomes letters from readers. Please submit double-spaced, typed letters that are limited to 250 words and include your name and address. Letters may be edited for space, style and grammar.

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commentary

Needed: Physician volunteers to care for indigent

John C. Bailey, M.D.
Commissioner, Indiana State Department of Health

At both the state and national levels, a wide variety of systemic health care reforms are under debate. A prerequisite of all proposals is the need to ensure access to quality medical care for the indigent.

As the health care delivery system has changed over the course of time, and the cost of both public and private health care has climbed, the evolution has exacerbated access problems for the economically disadvantaged. More than ever before, as the most vulnerable group in an increasingly fragmented society, the indigent and needy find themselves exposed to tremendous stresses in trying to survive without sufficient financial, political or medical resources. Health care professionals are in a unique position to provide assistance.

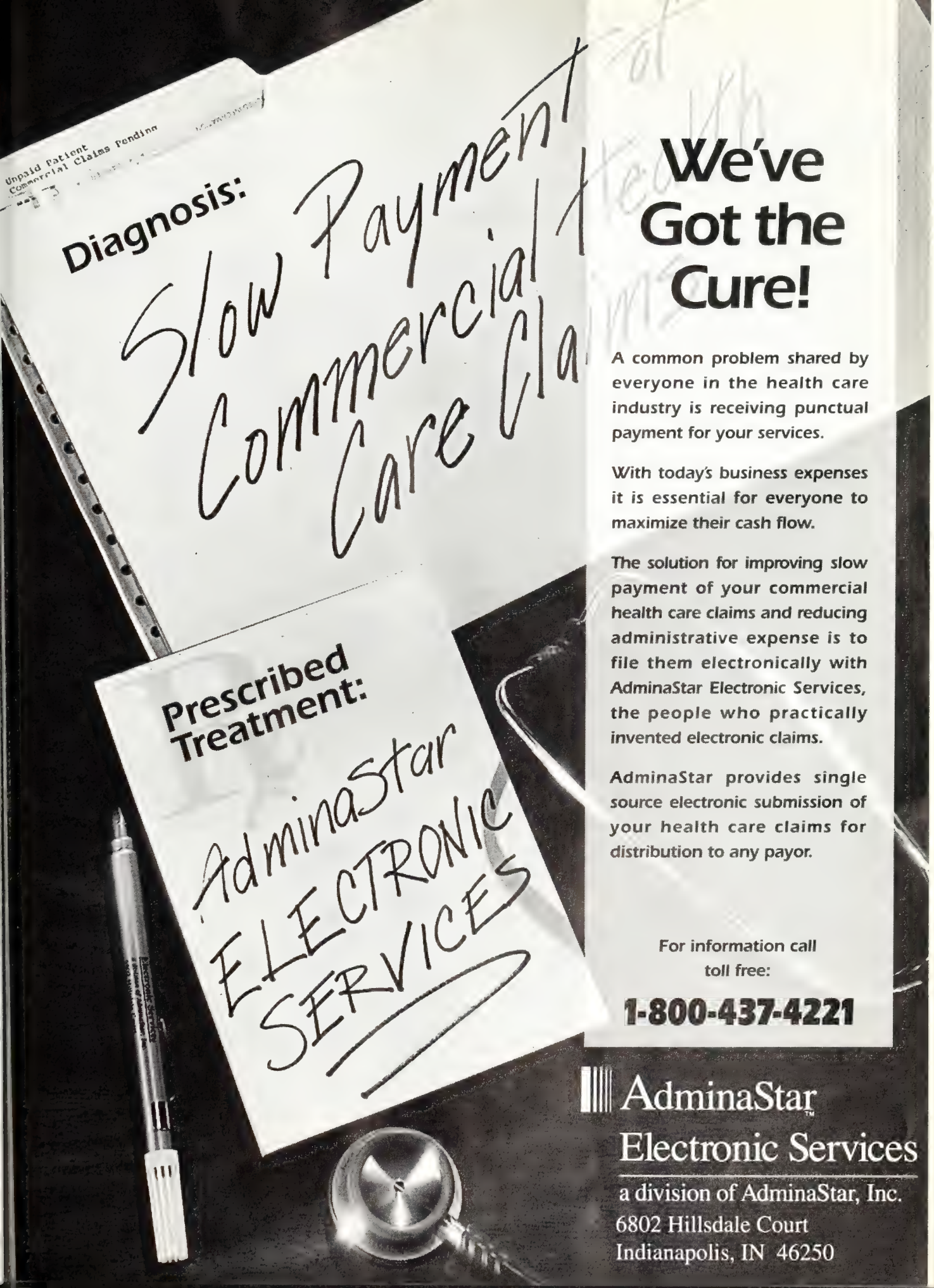
Our health care system has been built on a foundation of pluralism –public responsibility, private enterprise and individual volunteerism. Volunteerism is not a new concept in this country. It is, nonetheless, a reawakened concept, as evidenced by President Clinton's calls for community service among our youth.

Medical volunteerism is not new either. Through the years, as disasters or epidemics threatened, medical professionals have been among the first to lend assistance, and it has long been a practice for many physicians to accept whatever form of compensation that could be mustered as payment for services. In times past, this arrangement frequently displaced the need for formalized volunteer health services, but times have changed.

Increasingly, the indigent must rely on the public sector – a public sector desperately seeking a fair way to subdivide a finite fiscal pie. That makes medical volunteerism vitally important.

Volunteerism always has been, and continues to be, one of our greatest national resources. Through the collective efforts of such organizations as the Gennesaret Free Clinic in Indianapolis, Matthew 25 in Fort Wayne and at least 15 more clinics in communities throughout Indiana, concerned health care professionals are volunteering their time and talents to meet a growing need.

The debate over systemic health care reform will continue at both the state and national levels. Though the series of circumstances that evolved into the current health care crisis are multilayered and complex, certain factors in practicing medicine will not change. The practice of medicine has always involved strong elements of service to the communities in which we live. Now, more than ever, we need dedicated health care professionals who will provide competent, accessible and compassionate volunteer medical care to the community of the underserved. ❑



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commentary

Are you volunteered out?

Lynn H. Clothier
Indianapolis

James Trippi, M.D., in his article "Volunteer Health Care in Indiana" (page 220 of this issue), explores the reasons health care professionals become regular volunteers in the direct provision of health services to the poor in Indiana and discusses the potential results of their volunteerism. I would suggest that health professionals in many areas of the state are so overburdened by the effects of their missing peers, that volunteering isn't a choice. Or perhaps conversely, volunteering in a health professional shortage area masquerades as a way of life.

In January, a report of the Indiana State Department of Health summarized the areas of the state that have historically been designated as Health Professional Shortage Areas (HPSA) by the U.S. Public Health Service. The report shows 28 of our 92 counties to be designated (either whole or in part) as having fewer than one primary care physician for every 3,500 people, while the current state average is 1:1,465. A primary care physician is defined as a general practitioner, a family practitioner or a non-specializing internist, pediatrician or obstetrician/gynecologist.

In addition, the report shows 44 counties in which a shortage of health professionals joins other factors, such as poverty, elderly populations and infant mortality, to create undesirable health outcomes by virtue of either insufficient health resources or lack of access by all people. These 44 counties are further designated, either whole or in part, as Medically Underserved Areas (MUA) by the U.S. Public Health Service and can be likened to the medical equivalent of disaster areas. They would be eligible for special federal health services assistance, called community health centers under §330 of the U.S. Public Health Service Act, except that since 1980 increases in funds have been limited. Fifty Indiana counties are involved in these shortage designations: six are HPSAs only, 22 are MUAs only, and 22 are both HPSAs and MUAs.

Many health professionals in these shortage areas attempt to rise to the level of demand either by taking on more patients with public insurance, such as Medicaid or Medicare, or by providing increasing amounts of uncompensated care. Some of these practitioners have suffered severe medical problems from years of stressful overwork; others have become loud critics of the payor systems that are attempting to bridge a chasm in services; and others quietly become leaders of the community-based efforts to develop a better system.

All too often in these areas of the state, physicians and other health professionals find the volume and consequence of unmet health care so overwhelming that hey turn away from the pain of this problem and refuse to acknowledge its existence. Some adopt the philosophy that those without resources have deliberately caused their situation and, therefore, are undeserving of health care. Still others lose sight of the growing differential between income and the cost of health care and truly believe that each person can afford medical care at today's prices. But in these areas, all too few volunteer in the manner Dr. Trippi describes.

Today's dynamic but challenging health care environment offers health professionals in all areas of the state opportunities to serve the cause of healing. Volunteer health professionals are needed in a variety of capacities in all homeless shelters; battered women shelters; Head Start centers; youth centers, programs, and camps; Step Ahead councils; Women and Infants and Children (WIC), Maternal Child Health (MCH) and family planning programs; migrant labor camps; health departments; and health centers.

In these programs, direct care is a choice for the volunteer, but so is leadership. Leadership can take the form of chairing or participating in a community task force; serving on a board of directors; participating in health screening programs; providing advice on quality assurance, medical protocols and/or health care plans; or preceptoring medical students, medical residents or mid-level practitioners. Even agreeing to be a paid provider in a publicly funded program makes a strong statement to one's colleagues. Is not the physician who provides prenatal care at the local public clinic – even for a fee – a volunteer in the war on health access for all?

Effective health care volunteering in Indiana depends on sufficient health care professionals. In areas where professionals are in short supply, many health professionals have not participated in forums to develop solutions, in part due to the insistent demands on their expertise. However, health professionals are needed now, more than ever, to be leaders in the efforts that will ultimately bring the levels of supply and demand closer together.

Perhaps sooner than later,

health care reform will come to America with its promise of affordable, available and acceptable health care for all residents. Health professionals should be the leaders in the reform effort, particularly at the community level.

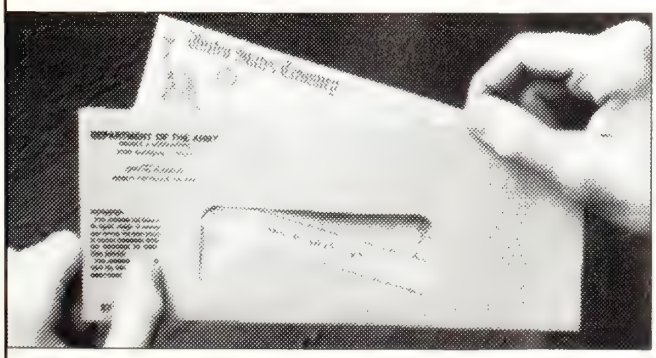
Unless the health professionals in each of our designated communities join other local leaders in addressing the need for health professionals, health resources and improved health access, reform efforts will have little local impact. Then, no amount of volunteering will be sufficient. ❑

The author is president of the Indiana Health Centers Inc.

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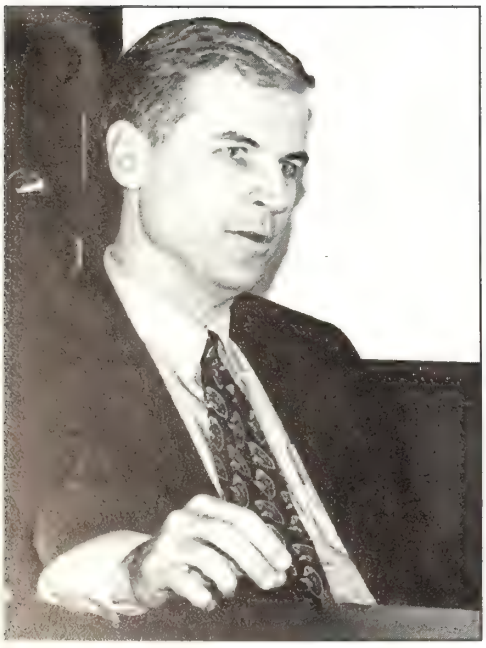
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Assisted suicide is

Bob Carlson
Indianapolis



Legalization of physician-assisted suicide somewhere in the United States is only a matter of time. That prediction came from Gregory Gramelspacher, M.D., in a recent interview with INDIANA MEDICINE on this controversial topic. While he does not expect Indiana to be among the first states to take that step, he likened the prospect of legalized physician-assisted suicide to legalized abortion, in the sense that each physician will have to decide whether or not to participate.

Dr. Gramelspacher is active in the dialogue on euthanasia and physician-assisted suicide as a speaker, researcher and author of papers on medical ethics, focusing on AIDS/HIV infection, ethics committees and decisions to withhold or withdraw life-sustaining treatment. He is also a frequent participant in symposia and media interviews.

In the following conversation with INDIANA MEDICINE, Dr. Gramelspacher contends that the debate itself about legalizing physician-assisted suicide is in some measure a consequence of the medical profession's inattention to its own highest ideals. He offers his frank views on physician-assisted suicide, on Dr. Jack Kevorkian, the Michigan physician who has helped 15 people commit suicide, and on the challenges of caring for terminally ill patients. He also shares his concerns about the role of money in medicine, and he responds to some of the most persuasive arguments for legalizing physician-assisted suicide.

Dr. Gramelspacher is an assistant professor of medicine at the Indiana University School of Medicine and the Regenstrief Institute for Health Care in Indianapolis. He is also a faculty associate at the Poynter Center for the Study of Ethics and American Institutions at Indiana University in Bloomington. He practices general internal medicine at Wishard and University hospitals in Indianapolis, directs the medical school's program in medical ethics and teaches clinical ethics to medical students and residents.

He is a graduate of the Indiana University School of Medicine in Indianapolis. After completing his internship and residency at the University of Michigan Hospitals, he practiced medicine in east Tennessee with the National Health Service Corps. He was a fellow at the University of Chicago at the Center for Medical Ethics. He belongs to eight professional societies and is the recipient of numerous honors, awards and grants. Dr. Gramelspacher is also active in service to his profession, the university and the Indianapolis community.

INDIANA MEDICINE: **What can physicians do to ensure that their terminally ill patients have a pain-free and dignified death and do not have to turn to physician-assisted suicide as a way of escaping suffering?**

Gramelspacher: I think the most important thing is to talk to patients, to recognize their pain and suffering, to pay attention to it and to treat it adequately with pain medication and with whatever other comfort measures we can. I think it's very important to educate young physicians in not only the technology of medicine, but the appropriate use of tech-

'bad for medicine'

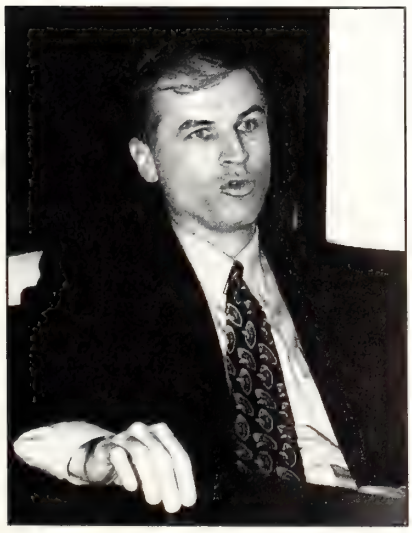
nology; to educate physicians not only when to use that high-tech medicine, but also when to back off and say enough's enough; to recognize when the patient can no longer benefit from that technological intervention.

INDIANA MEDICINE: **Do you see the current emphasis on cost containment as a factor in this question?**

Gramelspacher: I think so. You can't ignore it. [President] Bill Clinton, in his economic summit, said that if somebody tells you it's not a money problem, they're talking about somebody else's money. I think that's true. It's always a money problem, and especially now in this era of cost containment and health care reform, money is a critical component of anything you talk about in medicine.

I think there are other reasons why this has gotten such attention, but certainly money is an issue. It's something we should be very cautious about. Is this simply a way to save our society money? Do we spend too much money on people at the end of life? Do we overtreat patients at the end of life? Is physician-assisted suicide simply a way to save a lot of money?

I'd like to draw a distinction between allowing a patient to demand a certain treatment, in this case active euthanasia, versus allowing a competent patient to refuse treatment, or passive euthanasia. We're much more comfortable now with allowing patients to refuse treatment. There are still a few doctors who believe that you can't withhold or withdraw



> ***"I think a competent patient can refuse any medical treatment for any reason, and we should be comfortable with that."***

treatment. Now most physicians are comfortable with withholding or withdrawing therapy, allowing the patient or the patient's family the right to refuse unwanted medical treatment. I think a competent patient can refuse any medical treatment for any reason, and we should be comfortable with that.

The first right-to-die case was Karen Ann Quinlan in 1976. So we're 17 years away from that. That had to do with a ventilator, and at that time, it went all the way to the New Jersey Supreme Court. When the family of Karen Ann Quinlan, who was in a coma, asked the doctors to stop the ventilator, they said, "Oh, no, we can't do that because stopping the ventilator would cause her to die and then we would be directly implicated in causing her to die." [The family] had to appeal to the New Jersey Supreme Court and the court said, "No, she has a right to refuse medical treatment. That's all the family's requesting here. You're not obliged to provide treatment that they don't want, even though it may lead to her death." So the New Jersey Supreme Court said of course she can refuse or the family on her behalf can refuse medical treatment, and you have to stop the ventilator.

That was the first right-to-die case. There've been a great number of right-to-die cases since then. Now most of the right to die cases have to do with simple medical treatment such as nutrition and hydration. Most courts, including the Indiana Supreme Court, have acknowledged the patient's right to refuse even nutrition and hydration.

INDIANA MEDICINE: **Are there any precedents in history for physician-assisted suicide?**

Gramelspacher: There's a 2,500-year precedent proscribing physician-assisted suicide or euthanasia. And there are good reasons, I think, why our society prohibits killing, homicide, and in this case physician-assisted suicide. The historical example that comes to mind is the Nazi doctors in the Second World War who euthanised prisoners for medical experiments. The Nazis believed that certain lives were "unworthy

of life." That is one example where physicians actually participated, not so much in physician-assisted suicide – these people weren't asking to be killed – but in involuntary euthanasia.

I think physician-assisted suicide is the first step [from] a policy of voluntary euthanasia, where you could ask me to end your life and I would actually do the killing by a lethal injection, to one of involuntary euthanasia, where you don't ask me, but I decide your life isn't worth living any longer, and so I give you a lethal injection.

There are some people who suggest that this is what's happening now in the Netherlands. Here's a recent historical example where a country, a liberal democratic society, has not legalized but has accepted the practice of physician-assisted suicide and euthanasia. They've accepted it by prosecutorial discretion. In other words, if you follow certain steps, prosecutors in the Netherlands won't prosecute a physician if he ends his patient's life. The fact is, doctors don't always follow the policy. One of five things that you have to report is that the patient died of euthanasia, and doctors are afraid to do that. Families don't want them to do it because it's a stigma to the family. Doctors don't want to do it because they don't want to make their case in front of the prosecutor. But some people report that as many as 10,000 or even 20,000 people a year in the Netherlands die from euthanasia, and that not all of this is voluntary, that some people can't request it because they're old or demented, but the families may request it or the doctor decides that this is enough.

That's real frightening to me, especially in our society. The Netherlands has a much more homogeneous society than we do. They have a very good social safety net, very good nursing home care. They take care of their vulnerable population, for the most part, better than we do. In a country like ours, it scares me even more as to what might happen if you legalized physician-assisted suicide or euthanasia.



INDIANA MEDICINE: **You would be very concerned, then, about the idea of the "slippery slope?"**

Gramelspacher: I know the argument that one thing leads to another, and I guess that's the argument I'm making here. But I'd like to say that there's a strong distinction, not just a gradual slope, but a very firm distinction in my mind and in the minds of most physicians, I think, between allowing someone to die of their underlying disease and actively intervening to end their life.

INDIANA MEDICINE: **In practice, sometimes, that distinction may be difficult to observe.**

Gramelspacher: In a few cases, and I can tell you one example: A dying cancer patient who's in extreme pain and requires intravenous morphine to keep his pain under control, and the morphine is in such high doses that it may depress his respiration. The doctor gives the morphine to relieve the pain – that's the intent – but an unintended secondary effect is that the patient may die sooner from depressed respiration. That is acceptable medical practice to me. This is the fine line, if you want to talk about fine lines, between the two.

The Catholic moralists have justified it by referring to the principle of "double effect," that your intention is a good intention, to relieve the patient's suffering with the narcotic pain medicine. An unintended secondary effect is that the patient dies sooner. It's acceptable because you're trying to achieve the first good effect, which is to relieve suffering. This distinction is one that I'm comfortable with and clinically makes sense to me in the example I just gave to you.

INDIANA MEDICINE: **Are there any other justifications put forward for physician-assisted suicide, other than relieving pain and suffering?**

Gramelspacher: I think the biggest one, and the one that rings true with most of the public, is the right to self-determination. It's a patient rights argument, that a patient has a right to self-determination and autonomy and that such a right should include the right to end one's life. It's a

strong argument. The final act of self-determination, if you will, is ending your own life. You can't get any more self-determining or autonomous than that.

But I find it awkward when we talk about rights in medicine. It immediately puts you at loggerheads, opposing viewpoints, my right versus your right. In medicine, we should talk more about shared decision-making between doctor and patient. Not an adversarial relationship but a caring, sharing relationship where you and I together decide on the best treatment plan. Even if you want to stick with the rights language, I think there are some things a patient cannot demand, and one of the things they can't demand is that I kill them. It would have a lot of negative consequences, I think, for medicine in general. I guess my best argument against physician-assisted suicide is that it's bad for medicine. It's contrary to what we as physicians have taken an oath to do.

INDIANA MEDICINE: **If physician-assisted suicide were to become legal, how do you see that affecting physicians and the medical profession?**

Gramelspacher: I think it probably will become legal in some jurisdiction. In both the recent referenda in Washington and California, it was narrowly defeated by a vote of 54 to 46. The polls right before the referendum indicated strong public support for this, and it was only last-minute lobbying and a lot of dollars and commercials that changed the vote. Eventually it will be legalized. Probably not in Indiana any time soon, but in some state, probably in the West.

INDIANA MEDICINE: **How do see that affecting physicians and the medical profession in that jurisdiction?**

Gramelspacher: Well, physicians will have to choose whether to participate or not. I think there'll be a small minority of physicians who will be comfortable with the legal safeguards and will be comfortable participating. I believe there are physicians who would be willing to participate. I suppose you could compare it to abortion before it became legal in all 50 states, where some states legalized abortions and others didn't. Even now, there are some states where it's difficult to get an abortion because very few physicians will do it. I think it would be similar in the case of physician-assisted suicide.

> ***"I guess my best argument against physician-assisted suicide is that it's bad for medicine. It's contrary to what we as physicians have taken an oath to do."***

INDIANA MEDICINE: **Assuming that depression is a problem that the terminally ill face, would it help if physicians saw that these patients got help for their emotional problems?**

Gramelspacher: I think depression is often part of terminally ill patients' diagnoses. We probably don't pay enough attention to it. Dying is a very difficult human problem, and we need to get better at managing all aspects of dying, from good pain control to good attention to the emotional problems, the depression and other family and social issues that go with it.

I think it's a good argument for not legalizing physician-assisted suicide, looking for an easy technological fix to a very difficult human problem. If we have an easy technological fix, such as a lethal injection, then we're going to pay less attention to good pain control or to managing depression and terminal disease or to all the other issues that we need to pay attention to. These include expanding the hospice movement and having more good home hospice and inpatient hospice care available to patients and families. Having the easy technical fix, I think, will detract from those efforts.

INDIANA MEDICINE: **Should physicians predict that someone has a terminal condition for which there is no hope?**

Gramelspacher: Medicine isn't a perfect science. It's an imperfect art and there's an art to prognostication. I think that we do need to prognosticate for our patients. I don't think we should say that the case is hopeless, necessarily, but I think we do need to get better at knowing when to give up trying to cure and pay more attention to

care and comfort. Sometimes we get trapped in this technological imperative, that we just need to continue to treat the medical disease or the medical problem and we don't pay attention to the other aspects. One of the things I teach is to learn when to say "enough's enough" and to change your focus from curing an incurable disease to caring for the emotional well-being and other needs of a dying patient. I think it's important to prognosticate but to be honest and to say that even in this hopeless situation there are things that we can do to make you more comfortable, to relieve your pain, to relieve your suffering, to treat your depression, to try to make it good for you and your family as you die.

We're often criticized in the medical profession for not being good communicators, that we don't listen to our patients, that we don't take time with our patients. But I've begun to think twice about that. Most physicians who take care of a wide assortment of medical problems, for instance, do take care of a lot of patients who are dying. I think most physicians are used to having their patients die, used to talking with patients and families about this, and I think maybe we don't give ourselves enough credit for the job we do in caring for patients and families.

There are always horror stories, and they often happen in a medical center. The family doctor isn't available, specialists are involved in the care and the communication and the relationship haven't been established. An emphasis on primary care, everybody having a family practitioner, is very important in this area – educating fewer specialists and more generalists. The family doctor has been doing this for a long time and does know how to deal with death and dying and how to take care of terminally ill patients and families who are grieving.

INDIANA MEDICINE: **Why has physician-assisted suicide become an issue now?**

Gramelspacher: I think there are a lot of reasons. Part of it is technology and the aging of our population. Old people are afraid of becoming prisoners of medical technology, and young people are afraid of getting old. They don't want to get old, they don't want to get sick, they don't want to face death and dying. They want to stay young, healthy, suntanned, and they don't want to consider the inevitability of growing old and dying. I think it's hard for them to accept. Maybe they're looking for an easy solution to what I said before is a very difficult human problem. It's kind of a fuel-injected solution: in the same way we fuel inject our cars we can handle this problem with some IV curare. We have to accept our limitations and be more comfortable with death and dying.

The reason [Dr. Jack] Kevorkian has drawn so much attention to this issue is because he's a doctor. At least he has that title. He's not licensed to practice medicine in the state of Michigan any longer, and they're attempting to take his medical license away from him in California. He's a retired pathologist. I don't know that he's ever gotten informed consent from anyone in his life as a medical doctor. He's trying to do that now and actually videotapes the conversations he has with patients and families. He's kind of an easy one to criticize, but he has a political agenda. I see him as using these patients as a means to his own end, which is to promote physician-assisted suicide and patient autonomy. If he weren't a physician, he would get much less attention.

The other thing is the money again. How much of our gross national product should we spend on medical care? Anything related to medicine now gets front page news, whether it's a new medical treatment, new medical technology, a new transplant or a new therapy. The medical-industrial complex now is so huge and commands so much attention that anything that draws your attention to this issue would draw your attention to euthanasia as well.

For a long time physicians hid their heads in the sand saying, "Well, we can't let money influence what we do for our patients." But that's a very naive idea. It's right there front and center. We can't hide our head in the sand any longer. We have to acknowledge the world we live in now and that money and economics is an important aspect of what we do in medicine. Seventy-five percent of what we spend in medicine is directly related to what physicians order. They're the key in health care reform. But we've done such a bad job of getting involved in the policy issues and trying to protect our own self-interest that other people now are doing it for us. And that's going to continue. We really haven't gotten our own house in order.

INDIANA MEDICINE: **Do you see Dr. Kevorkian as a symptom or as a cause?**

Gramelspacher: He's a symptom. Kevorkian, as I mentioned, is easy to criticize. He's got a long history. Even in medical school, he was proposing things like using prisoners as organ donors or for bizarre experiments. He's got a long history of trying to buck the medical profession and the establishment. It's a crusade of his. I think the publicity given to him is a symptom. It's kind of strange being here trying to defend the notion that physicians shouldn't kill their patients. I mean, where are we now in 1993 that you'd have to even do that? Something has seriously gone wrong, both with the practice of medicine and the public's perception of what medicine is all about.

INDIANA MEDICINE: **What is your personal view of physician-assisted suicide?**

Gramelspacher: I think it's bad medicine, and I think it would be bad social and legal policy to legalize physician-assisted suicide. For me personally, it's the final act of abandonment of my patient. It's acknowledging that I can't help their suffering except by ending their life and that I'm not going to be there with them as they die. It's saying you're going to take the easy way out and give them the lethal injection. "Here, go home with this prescription and be done with it and don't bother me any more. Don't come back to the clinic with all your problems because they're too much for me to handle." I really see it as a form of abandonment of the ideals of the profession.



There is a lot of economic pressure on the medical profession now. The assumption is that we overtreat patients at the end of life. When I talk to the public and when I talk to medical audiences, almost everyone agrees with that statement. But when you ask why physicians overtreat patients as they're dying, it's not clear what the motives are. Very few actually believe that it's because physicians want to make money on patients as they're dying. Most commonly they believe it's because family members want their loved ones to be treated aggressively. They find it difficult to say, "Doctor, stop, dad's had enough." They don't want to be the ones to say they did something that caused him to die. Physicians are uncomfortable with that, too, uncomfortable taking that responsibility. But we have to work at communicating better with patients and families and assume the responsibility to say "enough's enough."

What happens is that so many patients when they get this ill can't participate in their decision-making any longer. Patients will be in the intensive care unit or they'll be semi-conscious, and they can't really participate in directing their care. So a lot of emphasis has been placed on the notion of advance directives, that patients in advance tell doctors what treatments they want and what they don't want. While I think that's the right idea, I'm not sure in reality we're going to be able to accomplish much with advance directives. It's something that we're studying now. Is it better to write down in a living will, for instance, specifically what treatments you want and what you don't want? Or is it better to appoint a proxy decision-maker who will carry out your wishes? I favor the proxy. I'd rather have a conversation with a live human being at the bedside than rely on some written directive. Because the clinical conditions are so varied and there are so many treatment possibilities, I often find the specific directive not very useful.

INDIANA MEDICINE: **Could you discuss the proposed clinical criteria for physician-assisted suicide that are being proposed by Drs. Quill, Meier and Cassel? I think to many thoughtful readers, these doctors would be examples of very caring, concerned and highly professional physicians who happen to take a view that isn't the same as yours on this subject.**

Gramelspacher: That's right. Their article is titled "Care of the Hopelessly Ill – Proposed Clinical Criteria for Physician-Assisted Suicide."[1] There are those rare cases where patients have severe suffering, and the only reasonable option to physicians is death. I think those are very rare cases. I take an opposite view. I don't believe we need public policy or

guidelines to allow some room in those rare cases. I believe there's actually some room now, as much room as we need, in the principle of "double effect," which I already described. It is accepted medical practice, and I would argue that it's ethical, to give someone high doses of narcotics to relieve his suffering, knowing that he would die sooner with the narcotics. Again, it's trying to maintain a fine line and a fine distinction, and the reason to maintain it, in my mind, is because we have too much to lose by allowing physician-assisted suicide. Those few patients who have uncontrolled, unrelievable suffering at the end of life are rare. To allow them their right to self-determination and their right to die would cost too much. The medical profession and the public have too much to lose.

The reason we have so much to lose is that we don't do a good job now of ensuring that everyone has adequate access to good, high-quality health care. We don't always do well taking care of old, vulnerable patients who are incompetent or marginally competent. We need to get better at pain management. We need to improve our care of patients at the end of life. We need to advance medical treatment to find out whether we can improve the care of patients. For example, early in the AIDS epidemic, we thought Pneumocystis pneumonia was untreatable, and everybody would die if they had that. Now, because we've treated patients, we realize that many times patients leave the hospital and lead productive lives for months or years after that infection. For all those reasons, we have much to gain by continuing our present prohibition against physician-assisted suicide.

In their conclusion, [Drs. Quill, Meier and Cassel] state that physicians now, "to adhere to the letter of the law, must turn down their patients' requests even if they find them reasonable and personally acceptable."[2] That in fact isn't the case. Dr. Quill demonstrated that. He defied [the law] and published his case of physician-assisted suicide in *The New England Journal of Medicine*. The local grand jury wouldn't indict him because they thought what he did was reasonable. Many medical groups came out publicly and supported him.

> ***"... We have much to gain by continuing our present prohibition against physician-assisted suicide ."***

[Drs. Quill, Meier and Cassel] seem to think that this behind-the-scenes or individualized decision-making could be improved with good public policy. Personally, I don't believe that we can shape good public policy to deal with individual, tragic choices such as this. That's why I voiced objection to Indiana's adopting a law against physician-assisted suicide, despite being personally opposed to the practice. I've seen what's happened with other legislation, such as Indiana's living will law. This law, written in 1985, is inconsistent with other Indiana law, and yet they can't or won't change it. They've tried for three years to amend it, and each time it gets labeled the "euthanasia bill" and gets voted down. You can't legislate good compassionate medical practice, is my point. ❑

This interview was conducted by Bob Carlson, a health care communications consultant in Indianapolis.

References

1. Quill TE, Cassel CK, Meier DE: Care of the hopelessly ill: Proposed clinical criteria for physician-assisted suicide. *N Engl J Med*, 327:1380-1384, 1992.

2. Ibid, p. 1383.



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Volunteer health care in Indiana

James A. Trippi, M.D.
Indianapolis

When we think of American medicine, images of technology, science and advanced treatments come to mind. More recently, out-of-control expenses, inaccessibility and the millions who are excluded from medical care because of financial lack are included in the equation. Those in the United States without insurance are estimated at 37 million.[1]

Many solutions and proposals have been offered to address the health needs of the poor. National health insurance, employer-based universal health insurance and socializing the health care industry have been suggested as remedies for the ailing U.S. system. Politicians talk about tinkering with or completely overhauling the U.S. health care system. All of these steps will take years to implement and bring to final form. Meanwhile, the situation for the poor steadily deteriorates.

Government programs through the Veterans Administration, Medicare and Medicaid provide millions of needy Americans vital medical assistance. Specialized programs such as Native American Health Service, Stewart B. McKinney grants for homeless medical care and WIC (Women, Infants and Children) seek to fill gaps in medical coverage to the indigent. These services are staffed by full-time professionals who often work at below standard wages to serve their clients. Their dedication and interest in the medical needs of the poor are not to be minimized. Unfortunately, many of the poor still go without basic medical services in spite of commendable work by these full-time health workers.

Out of the ranks of the private fee-for-service health profession, many are now joining efforts to assist those left out of the U.S. medical delivery system. They are doing so by offering their talents and time for free. Encouraged by their professional societies[2] and in a spontaneous outpouring of sympathy and concern for the homeless and poor, volunteer doctors, dentists, podiatrists, nurses and allied health professionals are pitching in to help. Volunteers seek to address what they perceive as the unfulfilled health and related needs of the poor.

The motivation to volunteer

In general, volunteers are people who want to make a difference in their world with issues that are important to them. They believe that their caring and skills can make a situation better. Volunteers are rewarded when they see positive results from their labors. Many medical professionals wish to return to the community some measure of the benefits they have received. Through volunteering, medical professionals participate in their community's life.

Volunteer health care professionals often wish to provide care without the encumbrances of the fee-for-service world. As a volunteer, they can once again recapture some of the simplicity of a patient encounter. Absent are the insurance forms to complete, the third-party treatment mandates to follow and negotiations with third-party carriers. Without a price tag, the patient encounter distills into a simple healing gift.

For many volunteer professionals, being involved in charity care is a personally rewarding experience. Being a part of the indigent medical encounter, the professional observes a different lifestyle, sees the problems of poverty and inadequate health care firsthand, and understands the needs of the indigent more fully. For the concerned health care professional, this involvement in the lives of the needy is considered a privilege. The intangibles of receiving an indigent patient's gratitude, knowing that a solution would not have been addressed without one's involvement and answering a call of faith can be more satisfying than financial remuneration.

Type of people volunteering medical expertise

Medical people of faith frequently become volunteers in charitable efforts. They may be interested in espousing their faith to those they treat or wish for their works to speak for themselves. Often their impetus is a desire to pass on to others the spiritual fulfillment they have experienced themselves.

Young medical professionals often become volunteers. Idealism, flexibility, openness to new experiences and discretionary time make young medical people prime volunteers. Often younger people will volunteer to explore different career options. Also, additional medical experience is

possible for young health volunteers. Volunteering opportunities are important activities during the formative training years and, therefore, should be encouraged.

People who seek experiences in primary health care delivery often volunteer. They may be specialists, administrators or retired health professionals wishing to once again enjoy aspects of primary health care. Some who have had previous experiences in indigent health care or as missionaries may wish to once again provide charity care.

Most volunteer health professionals have an extra measure of energy and enthusiasm for their profession and wish to share it with those in need. They tend to be among the most capable and highly respected members of the health community. Their participation in volunteer programs brings their considerable skills and abilities to those who need them most.

Most volunteer health professionals have an extra measure of energy and enthusiasm for their profession and wish to share it with those in need. They tend to be among the most capable and highly respected members of the health community.

Individual volunteer health care activities

The giving spirit of volunteerism continues today in many individual forms of charity health care throughout Indiana. Kimberly Arthur, M.D., of Gary-Hammond sees patients in the St. Catherine Hospital obstetrics and gynecology clinic on a volunteer basis every third week. Mark McDaniel, M.D., comes to the Wheeler Mission in Indianapolis once a month to provide medical care to the homeless. Joe G. N. Garcia, M.D., with several medical students, treats and investigates pulmonary disease among migrant farm workers in the Kokomo area.

The physicians of the Indiana State Medical Association reported providing free or reduced care to 8.1% of their patients.[3] Some specialties provided reduced or free care to more than 50% of their patients. Faced with the overwhelming health care needs of the poor, individual medical professionals generously reach out to help.

Health care for the poor through volunteer organizations

Most health workers volunteer their time and talents through volunteer health organizations, which vary widely. Some organizations begin with a casual structure, yet many develop an extremely sophisticated program over time. In general, the most successful operations are those that serve the needs of both the indigent client and the volunteer health professional.

A volunteer operation may serve the homeless, working poor, youth and runaways, migrant agricultural workers, minority populations or those with particular afflictions such as AIDS. Some clinics restrict their attention to only one target group while others attempt to serve all needy clients. Some volunteer operations provide complete health care, including medical, dental, laboratory, pharmaceutical, diagnostic testing, psychological, spiritual, rehabilitative and social work services, whereas others are limited to a few services. Some volunteer services are provided free-of-charge, and others use a sliding scale fee to cover supplies and overhead. Some clinics have a few full-time or part-time staff.

Many question whether numerous volunteers can provide adequate continuity of care. However, thorough follow-up, based on well-documented medical records, communication with patients and accessibility, is more important than having the same provider at each visit.

Others doubt if health volunteers are as capable as full-time paid health professionals for the indigent. In general, volunteers bring the same professionalism to their charitable activities as they display in their day-to-day careers. Volunteers also tend to bring enthusiasm and concern to indigent health care. In contrast, full-time health professionals to the indigent are known for their dedication and their depth of un-

Table

Volunteer health clinics in Indiana*

City	Name	Phone	Services±	Target pop.**	Visits/yr	Began
Bluffton	Panos Free Clinic	(800) 552-2923	M,P,R	P	600	1991
Evansville	ECHO	(812) 421-9850	M,P,S	H, P	1,600	1990
Evansville	IMPACT	(812) 426-6152	M,D,P,S	P	1,500	1992
Evansville	Washington Ave.	(812) 424-9585	M,G,P,E	P	1,000	1990
Frankfort	Open Door Clinic	(317) 654-8574	M,O,G,S	M, P	1,200	1990
Fort Wayne	Matthew 25	(219) 426-3250	M,D,P,L,E,R	P, H	14,000	1976
Garrett	Matthew 25 of Garrett	(219) 357-4051	M,P	P	300	1987
Greenfield	Medical Assistance	(317) 462-5112	M,P,S	P	300	1992
Hammond	Hammond Shelter	(219) 836-4290	M,P	H	500	1990
Indianapolis	Gennesaret Free	(317) 262-5645	M,D,P,R	H, P	5,500	1988
Indianapolis	Student Health Care	(317) 630-8449	M,P	H	300	1989
Jeffersonville	Clark Co. Health Care	(812) 288-1476	M,G,P,S	P	720	1992
Lafayette	Community Health	(219) 742-1567	M,D,O,G,P	P	6,000	1988
Michigan City	Open Door Health	(219) 872-6766	M,D,P,S	P,H	2,000	1989
Muncie	Gateway Clinic	(317) 747-5795	M,P,S,R	P	3,300	1968
South Bend	St. Joseph Chapin St.	(219) 289-4231	M,G,P	P	2,000	1986
Terre Haute	Lighthouse Shelter	(812) 238-7301	M,P	H	550	1992

* Organizations staffed soley or primarily by volunteers. This list is compiled from multiple sources and may not be complete.

+ M denotes medical; P, pharmaceutical; D, dental; S, social work; O, obstetrics; E, education; L, laboratory; R, specialty referral; G, gynecology

**H denotes homeless; P, poor; M, migrant farm workers

derstanding to the particular needs of the poor. Ideally, the mixing of volunteers and full-time staff will complement each others' strengths.

Facilities for volunteer health care delivery

Volunteer medical operations often are situated in a central location where volunteers and equipment can be concentrated. This type of facility brings all the elements together for the care and treatment of the indigent. A centralized system is best suited to smaller communities or pockets of need. In larger communities, a centralized facility requires good transportation services to serve those who do not live nearby.

A decentralized volunteer system seeks to serve the indigent where they are. This can be done through multiple mini-clinics, located in shelters, housing projects, or service centers, or with mobile units. These volunteer operations intend to be convenient to the indigent by ministering to people where they are. A decentralized system requires much more logistical support and

creates substantial problems in providing infrequently needed ancillary services.

U.S. volunteer health organizations

In 1990, the Los Angeles Free Clinic and Free Medical Clinic of Greater Cleveland published the *Directory of Free and Community Clinics* in the United States.[4] The 1,500 organizations included are spread throughout the country. The *1992 National Free Clinic Directories* compiled by the Bradley Free Clinic of Roanoke sought to list those clinics that relied solely or principally on volunteers. Small communities and large cities have volunteer clinics. Some volunteer organizations see more than 30,000 visits each year with budgets of over $1 million. One hundred twenty organizations nationwide are listed, but the lack of networking is evident by the absence of many existing volunteer groups in this directory.

Indiana volunteer health organizations

There are many well-established volunteer health organizations in Indiana *(Table)*. These organizations are defined as volunteer if they rely principally on the work of health professionals who are not compensated for their services. All large metropolitan areas, as well as several smaller communities, have some form of volunteer health care. Most are fairly new organizations, but two (Gateway in Muncie and Matthew 25 in Fort Wayne) have operated for more than 15 years. These organizations garner considerable community and corporate support with surprisingly little governmental funding. The cumulative budget of the six Indiana organizations listed in the *1992 Free Clinic Directory* is $970,000. The cumulative number of patient visits to these Indiana volunteer clinics is 30,528, with an average of about $31 per visit. Some organizations provide care at an average of $9 per visit. Volunteer medical organizations provide cost efficient care compared to fee-for-service care, especially since these visits often include prescription medications, supplies and some form of counseling.

The impact of Indiana volunteer health organizations on their communities has gone largely unnoticed. Many of these organizations fulfill vital services that other programs have not adequately addressed. This quiet phenomenon of volunteer health care continues to build in Indiana and across the rest of America.

Future of medical volunteering/ needs of volunteers

Some have proposed that volunteer medical care may be the answer to indigent medical care needs.[6] Even though this form of health care is cost effective and eases the burden of governmental agencies, volunteer health care can provide only a small fraction of the services needed. Government, the insurance industry and the medical community must not leave indigent medical care to bands of good-hearted volunteers.

Yet, volunteers will continue to be needed unless health care delivery includes all people regardless of the ability to pay. Even if funding becomes available to the indigent through our existing health care systems, transportation support, outreach workers and coordination of services will be needed to accommodate the special needs of the poor. When quality health care becomes accessible, affordable and responsive to the special needs of the poor, volunteer health organizations may not be necessary.

Nevertheless, today's volunteers and their organizations have requirements in order to deliver their health services. First, even though volunteers do not profit from these activities, money is needed. Raising funds to provide for full-time administrative staff, supplies, medications and overhead expenses is an added burden on the volunteer health organization. Community and corporate support has been present along with limited governmental funds. Increased governmental support could dramatically improve the level of care provided in volunteer clinics.

Second, liability concerns for the volunteer health care professional should be limited. Otherwise, the volunteer health care provider incurs extra liability risk by donating services. Because of this "double cost" of volunteering, many are not able or willing to volunteer. Those health professionals without current malpractice insurance because of retirement or those in specialties whose malpractice does not cover primary care cannot volunteer without significant personal risk. States where there is liability protection for volunteer health care providers include Georgia, North Carolina, Florida, Virginia, Maine and Arizona. Tax breaks for volunteer health professionals are available in Colorado. By limiting malpractice liability to volunteers who serve the indigent, these states are fostering a cost effective supplement to existing provisions for the poor.

Third and most importantly,

volunteers need the continuing support of their communities. Through donations of supplies, money and facilities, many of the health care needs of the poor are being addressed. Where community support is present, volunteer health services can become a vital service to the most indigent. ❑

Dr. Trippi is a cardiologist in the Methodist Heart and Lung Institute and the founder and president of the Gennesaret Free Clinic in Indianapolis.

This manuscript is adapted from an address to the 1992 Health Care for the Homeless and Poor Conference presented Sept. 12, 1992, at the Indiana Government Center in Indianapolis.

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References

1. Freeman HE, Blendon RJ, Aiken L, Sudman S, Mullimix C, Corey C: Americans report on their access to health care. *Health Aff*, 6:6-18, 1987.

2. Lundberg GD, Bodine L: Editorial: Fifty hours for the poor. *JAMA*, 258: 3157, 1987.

3. Physicians respond to indigent care survey. *Indiana Med*, 83: 918, 1990.

4. Bess GM, Hiller M: *National Directory of Free and Community Clinics. Los Angeles Free Clinic and the Free Medical Clinic of Greater Cleveland*, 1990.

5. Diefenthaler, K: *National Free Clinic Directory*. Free Clinic Foundation of America, 1992.

6. Kelleher K: Free clinics: A solution that can work ... now! *JAMA*, 266:838-40, 1991.





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Physician volunteers 'give back to community'

Tina Sims
Managing Editor

Physicians throughout Indiana are finding time in their already demanding schedules to provide volunteer medical care to the needy. Their generosity in helping the poor and homeless usually stems from their need to "give something back" to their community. Even with their other obligations, most doctors say volunteering does not take much time.

Most would also agree with retired Fort Wayne surgeon, Michael Mastrangelo, M.D., who said that volunteer efforts often provide "a good access point for people in the community who have no one else to turn to" for health care.

INDIANA MEDICINE interviewed some of those physicians who are giving the needy that access point.

Teresa A. Beckman, M.D.
Dr. Beckman, an Evansville family physician, is the medical director of the ECHO (Evansville Coalition for the Homeless) Health Center, which opened in February 1990. She was involved in helping establish the center and now serves on its board.

Because her parents did volunteer work in Fort Wayne during her childhood, "I learned it [volunteering] while I was growing up," she said. Other factors also influenced her decision to volunteer. She says she was asked to help at the right time in her life and has the time and the means. In addition, she was motivated by the Bible's message to share with the less fortunate.

She finds reward in the "little victories," such as knowing that treating someone's previously undiagnosed hypertension – the most common health problem seen at the clinic – will reduce the chance that the patient will turn up later as a stroke victim in a hospital emergency department. Dr. Beckman also recalls the women with erythema nodosum who was unable to walk when she first visited the clinic. After diagnosis and treatment from the clinic staff, the woman's condition improved and she was able to return to work.

For some patients, the clinic provides more than health care. When the staff distributed packets of personal care items to patients at Christmas, one women said that probably would be the only present she would get.

Dr. Beckman also sees the limitations of the clinic doctors. Many patients cannot be helped, she says, because of the lifestyle choices they have made that adversely affect their health.

Still, the clinic apparently is filling a need. It recorded 500 patient visits in its first year of operation, but in 1992 the number of patient visits rose to 1,738.

Joe G.N. Garcia, M.D.
For three years, Dr. Garcia has spent many Sundays during the summer farming season volunteering at a migrant farm workers clinic in the Kokomo area. An internist specializing in pulmonary medicine at the Indiana University Medical Center in Indianapolis, Dr. Garcia is helping diagnose conditions such as hypertension, diabetes, tuberculosis and respiratory problems that previously had gone untreated in the farm workers.

He and other health care professionals organized a multi-disciplinary medical surveillance to help determine the health problems of the workers. The study filled a gap since very little was really known about the migrant worker's health problems, Dr. Garcia said. Because most of the workers were Hispanic, the questionnaire was also written in Spanish.

Dr. Garcia's interest in the migrant farm worker has roots in his childhood. While growing up in California, he worked in the strawberry and lettuce fields alongside Hispanic migrant workers. "I have a special soft place in my heart for the plight of the migrant farm worker because of my background," he says.

"It's one of the most satisfying things I've done as a physician," he says of his volunteering among the migrant workers. His service is a chance for him "to give something back," he says.

His special concerns include the children, many of whom suffer from respiratory problems such as bronchitis and wheezing. He attributes the conditions to factors such as agricultural chemicals, close living quarters, improper nutrition and limited access to health care. Because of the migrant workers' limited access to reliable health services, Dr. Garcia also worries that they may not always comply with their pre-

scribed treatment when they leave their work in Indiana to return to their home base in Texas.

Dr. Garcia's volunteer efforts include work among the homeless in Indianapolis. For the past two years, he has helped Ann Zerr, M.D., an internist at the Indiana University Medical Center, with her tuberculosis screening project at homeless shelters and later helped her treat those diagnosed with the disease at Wishard Memorial Hospital.

He encourages physicians to become volunteers. "It's one of the more rewarding things we can do. Anyone who got involved would feel good about it."

Michael Mastrangelo, M.D.
Dr. Mastrangelo, a retired Fort Wayne surgeon, can be found once or twice a week volunteering at the Matthew 25 clinic in Fort Wayne. He began serving there after he retired a year ago for the chance "to stay on the edge of medicine and continue to care for people."

Like the other physicians interviewed, Dr. Mastrangelo volunteers because he wants to contribute to the community – a community that has been good to him, he says. "It's a warm feeling to be involved with this."

A fund-raising campaign is under way to enlarge the clinic. The expanded building will have six examination rooms, enabling more patients to be seen. Now only one doctor at a time can examine patients.

Matthew 25 includes a dental clinic and a diabetes clinic staffed by volunteers. Besides the physicians who volunteer at the clinic, many specialists to whom patients are referred outside the clinic also donate their time. Many radiologists volunteer to read x-rays, for example, and patients with orthopaedic problems are referred to a free clinic sponsored by the city's orthopaedic residency program.

Dr. Mastrangelo, a board member at Matthew 25, says his work among the city's poor and homeless is "like being a general practitioner." While providing the best care he can, he also is careful to justify the necessity of any referrals or tests in order not to drive up the cost of care.

"We have a good rapport with the patients," he says. Angry patients are uncommon at the clinic, he says, so the volunteer physicians do not have the burden of practicing defensive medicine.

Charles R. Taylor, M.D.
Dr. Taylor, a Greenfield cardiologist, credits his involvement with the Gennesaret Free Clinic in Indianapolis as the impetus behind the establishment of the Medical Assistance Program (MAP) in Hancock County. MAP provides health care for the "working poor" who cannot afford health insurance or medical care.

After volunteering at the Gennesaret clinic, Dr. Taylor said he became interested in starting a similar program in Hancock County. "Some of my patients couldn't get the care they needed. There had to be some way to get around that," he said.

He teamed up with Dean Felker, M.D., current MAP committee chairman, and other physicians and began investigating possible ways to provide for people being left out of the health care system. What they eventually realized was that although Hancock County did not have many homeless people, such as those served by the Gennesaret clinic, it did have the working poor.

MAP was designed to specifically help those in that category. The social services department at Hancock Memorial Hospital determines if patients qualify for the program based on their incomes. Those who meet the criteria receive a MAP card and are assigned to a family physician. The physicians provide free care, and patients are also eligible for free hospitalization. MAP patients are re-evaluated every six months for eligibility.

About 90% of the county's physicians, including both primary care physicians and subspecialists, participate in the program. Dr. Taylor says physicians are "happy to do this if they know the person is needy."

Others have contributed to the program. Pharmacists offered to store the drug samples that physicians donate to the program. The hospital foundation provides some generic drugs.

Because physicians see the patients in their own offices, MAP patients "get the same respect as anyone else," says Dr. Taylor. About 200 people are enrolled in the program, which Dr. Taylor terms a "terrific success."

He says the program works well in counties with more limited numbers of people who cannot afford medical care. It also benefits many of the working poor who are not needy enough to qualify for any other type of financial medical assistance.

"It's important for physicians to take the lead" in helping the needy, Dr. Taylor says. "We've done too much sitting around." ❑



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Physicians under surveillance:

The National Practitioner Data Bank

Elizabeth A. Snelson, J.D.
St. Paul, Minn.

The National Practitioner Data Bank, created under the Federal Health Care Quality Improvement Act of 1986,[1] collects negative information about physicians and disperses it to hospitals, HMOs, medical boards and other entities to use against physicians. The effect on a physician's career can be devastating, yet few physicians are familiar with the data bank reporting system. The data bank requirements are so complicated that many reporting entities report unnecessarily to the clear detriment of physicians.

The Health Care Quality Improvement Act (HCQIA) encourages peer review by extending conditional immunity against antitrust liability. Many physicians justifiably fear participating in peer review as a result of huge antitrust judgments against doctors who participated in peer review decisions that curtailed other physicians' practices. The offer of immunity, however, is not without strings attached. To qualify for antitrust protection, the peer review must be conducted fairly, must follow standards of reasonableness and must meet minimum hearing procedures.

The immunity package also created the National Practitioner Data Bank, a national system for compiling and issuing reports on adverse actions taken against individual physicians, such as peer review actions, licensure restrictions and malpractice payments. Generally, the underlying objective of the data bank is good: to accumulate in a centralized system information that allows licensing boards, hospitals and other health care entities to restrict physicians whose practices have been found to be substandard. A prime reason for establishing the data bank was the fear that bad doctors were able to repeat their offenses and jeopardize patients simply by crossing state lines. Theoretically, with information demonstrating a physician's failings, the physician can be prevented from repeating earlier errors through limitations or denials of license, hospital privileges and practice opportunities. Unfortunately, data bank theory and practice have not proved consistent.

Because state statutes vary widely regarding what conduct merits licensure action, physicians in one state may be reported to the data bank for something that is not punishable or reportable in another state.

Problems with the statute

As with other legislation, intent and implementation of the data bank legislation diverged, starting with the statute itself. In some situations, the statutory language is too broad, and in others, too narrow. The statute misses the mark in each of the three categories of adverse information to be collected under the HCQIA.

Malpractice

To collect information about malpractice, the statute mandates the reporting of all payments made on behalf of a health care practitioner in response to written claims of malpractice. The statute specifies that only payments must be reported; waiver of a patient's bill is not reportable because no payment takes place. The statute also requires reporting of all payments made to settle claims, although it acknowledges that cases are often settled even when they lack merit.[*2] Thus, settlements of even the most frivolous claims count as adverse actions taken against physicians and are included in their data bank dossiers.

Licensure

The HCQIA requires all state licensing boards [including the Indiana Medical Licensing Board] to report when they restrict or revoke a physician's license for reasons related to professional competence or professional conduct. Because state statutes vary widely regarding what conduct merits licensure action, physicians in one state may be reported to the data bank for something that is not punishable or reportable in another state. A similar lack of uniformity exists for reporting of

physician impairment. Some states protect physicians whose chemical dependency, alcoholism or other impairment has come to the medical board's attention, based on the belief that it is preferable for the practitioner to come forward and obtain help rather than remain underground. If the physician submits to the state's "diversion" program, practicing under strict monitoring and therapy requirements, no disciplinary action is taken and no data bank report is filed. Other states categorize monitoring as discipline and report the physician to the data bank, effectively reducing the number of practitioners willing to come forward and submit to their boards' controls.

The HCQIA license reporting requirements ensure uniformity in one respect: The statute does not require state boards to report when they deny licensure. Only actions against licenses are reportable. Therefore, information that a physician has been denied licensure by every state in the nation could not be obtained by querying the data bank.

Professional review actions

The HCQIA requires reporting of adverse professional review actions that restrict privileges or membership if the action:

1. lasts more than 30 days;
2. is based on professional competence or professional conduct that affects or could affect the health or welfare of a patient; and
3. is taken by a hospital, a health care entity that provides health care services and follows a formal peer review process, or a medical society that follows a formal peer review process.

The sheer number of qualifiers built into the statute's complicated definition of reportable professional review action guarantees the use of loopholes in professional review. For example, hospitals are likely to impose 29-day restrictions to avoid filing reports, and health care entities and medical societies may refrain from adopting formal peer review processes to skirt the reporting requirement.

Problems with implementation

In addition to the problems created by the statutory language are problems arising from the statute's implementation. The Department of Health and Human Services issued regulations on Oct. 17, 1989,[3] behind schedule, and the data bank opened Sept. 1, 1990, also behind schedule. Its operations immediately bogged down under the large number of reports and queries filed and the confusion over reporting requirements. In an effort to assist reporting entities, the U.S. Health Resources and Services Administration (HRSA) published its *National Practitioner Data Bank Guidebook*[4] in 1990 and a *Guidebook Supplement*[5] in August 1992. Unfortunately, in several instances, the regulations and HRSA publications further confuse matters.

Consider the following examples and their ramifications for physicians.

Malpractice reporting

Starting with a literal interpretation of the statute, the guidebook states that payments made in the name of a corporation rather than a practitioner are not reportable because the statute mandates reporting of payments made on behalf of individuals. However, the guidebook goes on to create an exception for professional corporations that consist of only one person. Accordingly, payment of a malpractice settlement or judgment for a one-physician corporation must be reported, even if it is in the name of the corporation.

Because of this interpretation, many malpractice settlements have dropped the individual plaintiffs originally named in complaints, leaving corporations to make the payments; because corporations that include more than one physician cannot be reported, no data bank report is necessary.

A new interpretation presented in the supplement attempts to limit this loophole. Under the latest interpretation, a person dismissed from a malpractice lawsuit as a condition of settlement must still be reported to the data bank. The supplement interprets such a dismissal as a payment on behalf of the practitioner.[5] This interpretation is simplistic in several ways. It does not make clear whether the condition of settlement must be expressed in writing. It also assumes that there is always actual basis for naming a practitioner as a malpractice defendant. In reality, any practitioner on the chart or in the vicinity of an alleged incident can be named as a defendant in malpractice litigation. Under the supplement's broad interpretation, dropping the most blameless defendants may be seen as a condition of the settlement rather than as a correction to the complaint.

The supplement attempts to reinforce the statute's provision that a "payment in settlement of a medical malpractice action or

claim shall not be construed as creating a presumption that medical malpractice has occurred."[2] The supplement suggests that insurance companies disclose in the reporting form's narrative description section that settlement payment was made despite the insurance company's determination that the claim had no clinical merit.[5] Although insurance companies may be reluctant to document that they are settling claims in the absence of merit, a report without such a disclaimer may imply that the malpractice claim did, indeed, have merit.

Peer review

The supplement contradicts the guidebook on the issue of reporting summary suspensions, but it subsequently conditions its interpretation. The guidebook states that summary suspensions are not reportable unless they are considered professional review actions. Most medical staffs and hospitals define professional review action as only those actions adopted by the hospital board. The supplement first states that summary suspensions should be reported if they have been in effect more than 30 days, even if the hospital board has not yet acted on the matter. However, the supplement states that a summary suspension should be reported only if it is considered a professional review action under the medical staff bylaws. Thus, because bylaws control reportability of summary suspensions, medical staffs should consider amending their bylaws if they do not specify that summary suspensions are professional review actions only after adopted as such by the hospital board.

Operational quirks

The guidebook and the supplement also include instructions for submitting reports to and receiving information from the data bank, revealing a convoluted process, even if it functioned as planned. Forms are complicated to complete manually and were not electronically transmittable until late 1992. Even completing a self-query, a physician's request for his or her own file, is so unclear that the data bank recommends physicians call its "helpline" for assistance. (The data bank rejects forms with mistakes.)

The form features a narrative description section where the basis for reported action must be stated in 600 characters or less (including punctuation and spaces). Making this more problematic, a non-clinician is typically responsible for determining the clinical reasons for the action and synthesizing a 600-character description of the sometimes sophisticated case. The description is disseminated to all hospitals and health entities requesting information about the physician from the data bank.

Coding can lead to further ambiguity and inaccuracy. In addition to the narrative description, a code must be selected from a very limited list of categories for adverse actions. Usually, the same individual who drafts the narrative selects the code, which may or may not be a close match. Consider, for example, the difference between "narcotics violations" and "substance abuse." Narcotics violations could include federal crimes, whereas substance abuse refers to the physician's medical condition.

The lack of clear guidelines and uniform reporting procedures is of serious concern because once a report is filed, it is very difficult to change. Only the reporting entity can file a correction. Physicians have no right to correct misinformation in their data bank files. Even if a physician is successful in convincing the reporting entity to submit a correction, the data bank will not delete the incorrect report originally submitted. The correction is merely added to the physician's file, leaving the incorrect information to be disseminated and considered by those reviewing the file. If a court overturns action taken by a state board or hospital, the data bank will register it as a revision to the original action. Thus, even if the U.S. Supreme Court judges the original adverse action illegal, the information is not deleted from the physician's file. In fact, data bank files are permanent and are not deleted even upon the physician's death.

What can physicians do about the data bank?

Because physicians have very limited opportunity to correct or dispute the information contained in their data bank files, it is important that they take the following steps to prevent the unjustified or inappropriate filing of data:

1. Request that reporting entities adopt procedures to lessen the possibility of unnecessary or inaccurate reports being filed. Medical staffs, HMOs, clinics and other health care entities, particularly professional liability insurers, should have procedures in

place to ensure that reports are reviewed by clinicians for accuracy and that individuals are granted opportunity to review reports before they are filed.

2. Make sure defense counsel and attorneys assisting in the preparation of procedures understand the data bank, its loopholes and varying interpretations. Even most lawyers consider the data bank's requirements Byzantine.

A physician who is reported can expect to be notified by the data bank and should give immediate attention to anything received from the data bank.

Conclusion

Complex statutory provisions further complicated by the bureaucracy's interpretations and demands make it very difficult for physicians and reporting entities to comply with data bank requirements. Over-reporting in some circumstances, under-reporting in others and lack of uniformity throughout the system render data bank information unreliable. Yet, despite the questionable worth of the system, it cannot be ignored. ❑

** "A payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred."*[2]

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The author practices law in St. Paul, Minn., representing medical staffs, medical societies and physician interests in Minnesota and across the country.

References

1. 42 USC. 11111-11152 Public Law 99-660 (Nov. 14,1986).
2. 42 USC 1320(a).
3. 45 C.F.R. § 60 et seq.
4. Department of Health and Human Services. National Practitioner Data Bank Guidebook: A reference for individuals and entities reporting to and querying the data bank. Rockville, Md: Bureau of Health Professions, U.S. Health Resources and Services Administration, 1990.
5. Department of Health and Human Services. National Practitioner Data Bank Guidebook Supplement: Current references for data bank users (individuals and entities reporting to and querying the data bank). Rockville, Md: Bureau of Health Professions, U.S. Health Resources and Services Administration, 1992.

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Handling your retirement distribution under the new withholding rules

Joel M. Blau, CFP
AMA Investment Advisers, Inc.

As though the rules surrounding retirement plan payments weren't complicated enough, Congress enacted new legislation requiring 20% withholding from certain payouts received after 1992.

The new rules apply only to recipients of lump-sum retirement plan distributions.

The new tax rules make it crucial to make arrangements before receiving a distribution. A lump-sum payment received directly by you after 1992 generally will be subject to 20% withholding.* Note that the taxation of retirement plan distributions has not changed. The withholding is simply deducted as advance payment of any taxes due, which are calculated upon filing your annual income tax return.

Lump-sum payments from a qualified retirement plan can be rolled over into an Individual Retirement Account (IRA), which allows your money to continue growing tax-deferred. You won't be subject to 20% withholding if you make prior arrangements to have the benefits paid from your retirement plan directly to the IRA trustee. In other words, you cannot personally take possession of the money without paying withholding.

If you receive a lump-sum payment directly, you can still roll the money over into an IRA within 60 days of its receipt. However, a $100,000 distribution would be reduced to $80,000 (after 20% withholding). If you wanted to roll over the entire distribution into an IRA, you would have to contribute the additional $20,000 from your personal savings. The withholding could not be recovered until you filed your annual tax return and received your refund check.

The new tax rules make it crucial to make arrangements before receiving a distribution.

It may be advantageous to have your retirement balance paid into an IRA even if you want to take possession of the money. Reason: You can withdraw from an IRA without being subject to mandatory withholding. Of course, IRA withdrawals will be subject to income tax and any applicable penalties. Also note that withdrawals from an IRA are not eligible for special averaging, an election that helps some individuals reduce income tax on retirement plan distributions. ❑

** At press time, a bill including technical corrections to the new rules was pending and could exclude certain distributions from the withholding requirements. Check with your tax advisor for the latest available details.*

The author is a senior financial counselor with AMA Investment Advisers, an AMA subsidiary. He welcomes readers' questions and can be reached by calling 1-800-262-3863.



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Other benefits include health coverage via Arnett HMO or other group insurance, disability, and life insurance plans. A generous fund for continuing education is available to clinic physicians.

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Lafayette, Indiana is a thriving, low-crime community located in a county of approximately 132,000 people. Purdue University, known for academic leadership in the areas of engineering, agriculture, humanities, and sciences, and for Big Ten Sports, is nearby. *Money Magazine* recently identified Lafayette as one of the top 14 cities in which to live in the U.S.A.

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Premenarchal vulvovaginitis

Margaret J. Blythe, M.D.
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Premenarchal vulvovaginitis is a common disorder that accounts for 85% to 90% of gynecological problems in this age group.[1] Symptoms and clinical findings are variable and may include pruritus, local erythema, pain, enuresis, dysuria and labial adhesions.[2]

Biologically, premenarchal girls are at increased risk for developing vulvovaginitis. The relative lack of estrogen in the prepubertal patient results in a thin, atrophic vaginal mucosa that is easily traumatized. This finding, along with a neutral to alkaline pH in the vagina, produces an environment ideal for bacterial overgrowth. Also, the vagina is close to the anus and urethra, allowing for easy fecal and urinary contamination. Adding to this risk, the prepubertal vagina lacks the protection of the labia, which will be thickened later by estrogen stimulation and covered by pubic hair. Finally, most prepubertal children have relatively poor perineal hygiene, resulting in a relatively constant exposure to irritants.[1,3]

The following case report illustrates a typical presentation of a premenarchal child with vulvovaginitis.

Case report

A white female age 4 years and 10 months presented with a history of recurrent vaginal discharge. According to both parents, the discharge had been intermittent since she was 2 years old, around the time of potty-training. The discharge recently had increased in quantity and had become yellow-green in appearance. The discharge was associated with symptoms of irritation, resulting in pain on urination and discomfort wearing clothes.

The mother denied any noticeable changes in the patient's eating, sleeping or playing behaviors. She said her daughter had taken several rounds of oral antibiotics. Many topical antifungal creams also had been tried. The child became resistive to any of the mother's attempts to wash the girl's genital area. The mother had noticed no physical changes suggesting early onset of puberty. She was not aware of the child's attempting to place objects in her vagina or of increased episodes of manipulating or rubbing her genital area.

The mother confirmed that

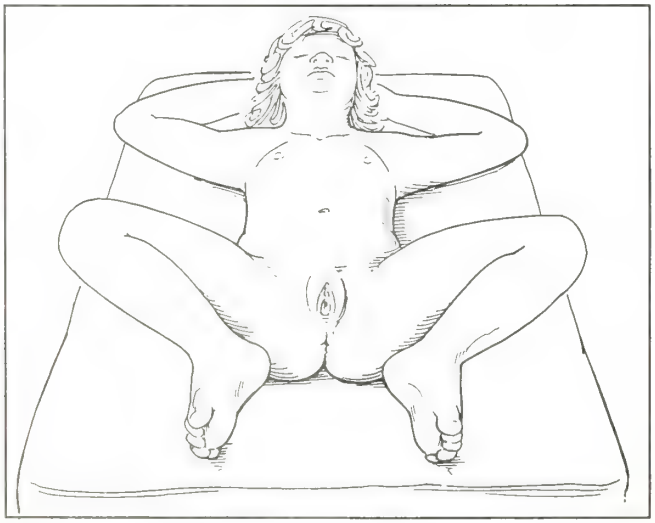


Figure 1: Prepubertal child supine in frog-leg position.

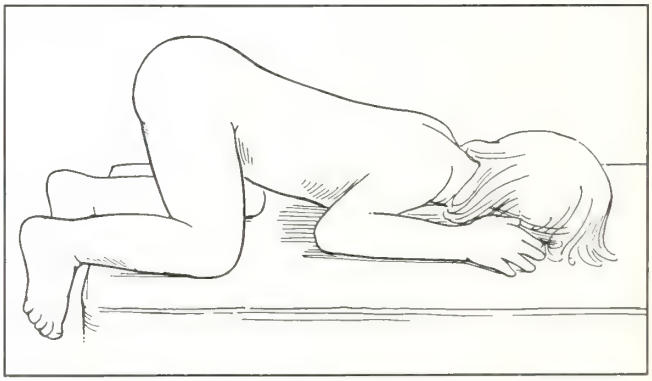


Figure 2: Prepubertal child in knee-chest position.

the birth history was unremarkable and said she had taken no medications except vitamins and iron while she was pregnant. The patient's birth weight was appropriate at 7 pounds 12 ounces. The mother carried the baby to full term, had a normal vaginal delivery and went home within three days of delivery. The mother verified that she had had no concern regarding the potential of sexual abuse. The mother provided care for the child, but the girl had started attending preschool two half-days per week a few months earlier. The patient lived with both of her biological parents and her 5-month-old brother. She had no known allergies or history of constipation and was not taking any medications. Her weight, height and vital signs were all appropriate for age.

Discussion

In the evaluation of vulvovaginitis, a thorough history should be taken from both the parent and, if old enough, the child. Specific emphasis should be on the onset and accurate description of discharge, associated symptoms, past illnesses, prior antibiotic therapy or other medicines, along with recent growth and development, potential trauma, past history of foreign bodies, perineal hygiene and the possibility and/or concern regarding sexual molestation.[2]

A general physical examination with emphasis on sexual maturation along with a thorough evaluation of external genitalia should be performed. The exam requires patience and gentleness. Furthermore, an internal examination is usually not necessary unless there is concern of a foreign body, vaginal bleeding or a chronic, unexplained vaginal discharge.[4,5]

Table 1

Etiologic factors of premenarchal vulvovaginitis

I. Bacterial
- A. Nonspecific
  1. Poor perineal hygiene
  2. Intestinal parasitic invasion with pruritus
  3. Foreign bodies
  4. Urinary tract infections with irritation
- B. Specific
  1. Group A: B-hemolytic Streptococcus
  2. *Streptococcus pneumoniae*
  3. *Haemophilus influenzae*/parainfluenzae
  4. *Staphylococcus aureus*
  5. *Neisseria meningitidis*
  6. *Escherichia coli*
  7. *Shigella flexneri/sonnei*
  8. Other enterics
  *9. *Neisseria gonorrhoeae*
  *10. *Chlamydia trachomatis*

II. *Protozoal-Trichomonas

III. Mycotic
1. Candida-albicans
2. Other

IV. Helminthiasis-Enterobius Vermicularis

V. Viral/Bacterial Systemic Illness
1. Chicken pox
2. Measles
3. Pityriasis
4. Mononucleosis
5. Scarlet fever
6. Kawasaki disease

VI. Other Viral Illnesses
*1. Molluscum contagiosum in genital area
*2. Condyloma acuminata
*3. Herpes simplex - type II

VII. Physical/Chemical Agents
1. Sandbox
2. Trauma
3. Bubble bath
4. Other

VIII. Allergic/skin conditions
1. Seborrhea
2. Lichen sclerosis et atrophicus
3. Psoriasis
4. Eczema
5. Contact dermatitis

IX. Tumors

X. Other
1. Prolapsed urethra
2. Ectopic ureter

** sexually acquired*

The exam usually consists of proper positioning, inspection and gentle probing for appropriate sampling information and a rectoabdominal exam. In the older child, the conventional lithotomy position with appropriate draping is best. In the younger child, the frog-leg position, supine with heels together and knees apart *(Figure 1)*, or the knee-chest position without draping may be less threatening *(Figure 2)*. The physician should offer an explanation of the procedure and words of reassurance while performing the exam. For prepu-

bertal children under the age of 10, the presence of a parent or guardian is helpful.[4,5]

The physician should inspect the genitalia for presence or absence of pubic hair, size of the clitoris, perineal hygiene and the appearance of the posterior fourchette (friability, erythema, abrasion, tear, laceration, scar). The vagina is best visualized by pulling the labia laterally and posteriorly while depressing the perineum with both thumbs or gently gripping the labia majorum and pulling forward. The hymenal shape, the size of its opening and any discharge should be noted.[4,5]

After careful inspection, vaginal secretions should be obtained for appropriate studies. Several methods can be used. One method is to insert a cotton-tipped, urethral aluminum swab, pre-moistened with non-bacteriostatic saline, into the vagina, being careful not to touch hymenal edges. Another option is to use a plastic or glass eye-dropper with 4 cm or 5 cm intravenous plastic tubing. After inserting a few drops of saline into the vagina, aspiration of the secretions with this tubing may be performed.[4,5]

Appropriate studies in the evaluation of vulvovaginitis are a routine vaginal culture along with cultures for *N. Gonorrhoeae* and *C. trachomatis*. An aluminum cotton-tipped urethral swab must be used when obtaining a sample for a chlamydial culture, while the aluminum urethral or Calgi swab may be used for obtaining a sample for a gonorrhea or routine culture. A wet prep is optional but may be helpful in looking for trichomonas, epithelial cells, white blood cells, red blood cells, pinworms and mycelia.

The rectoabdominal exam should conclude the procedure. The finger is placed in the rectal vault and swept over the anterior wall of the rectum to rule out any abdominal masses or tumors, express vaginal discharge and palpate for possible vaginal foreign bodies.[4,5]

In diagnosing premenarchal vulvovaginitis, a wide variety of etiologies should be kept in mind *(Table 1)*. The most common diagnosis is nonspecific, bacterial vulvovaginitis secondary to poor perineal hygiene. The vaginal culture may reveal a predominance of coliform bacterial or normal vaginal flora with the wet mount showing many white blood cells.[1-3,6]

Bacterial vulvovaginitis also may be secondary to bacteria acquired from self-inoculation with pathogens from the upper respiratory tract and/or gastrointestinal tract. Specific bacterial vulvovaginitis is common, particularly for children in day care or preschool. It is characterized by a vaginal culture revealing an organism related to a specific disease process with a respiratory or gastrointestinal pathogen. These bacteria are listed in *Table 1*.

Treatment protocols are standard antibiotics dictated by the specific organism isolated. Other causes may include mycotic infections (especially with a history of preceding antibiotic therapy or

Table 2

Treatment for nonspecific vulvovaginitis

1. Instruct to give sitz baths twice a day with warm water and 3 tablespoons of baking soda for 10 to 15 minutes for seven days. If no improvement, needs further evaluation. If improved, continue one sitz bath per day indefinitely.
2. Review wiping (i.e., front to back with blotting technique).
3. Use white, cotton-crotched panties with frequent changes.
4. Wear loose fitting clothing.
5. Avoid using soap locally as well as bubble bath, topical wipes, sprays, powders, creams or ointments unless prescribed.
6. Avoid rubbing the area, as natural body oils that protect the skin from irritation may be removed.
7. Launder panties with normal detergent in warm water. If bleach is needed to remove stains, double rinse panties.
8. Minimize bath time in contact with soap. Use soap and shampoo at the end of bath time.

uncontrolled diabetes); a variety of viral illnesses; physical, chemical and allergenic agents; skin conditions; tumors; and urologic problems, such as a prolapsed urethra or an ectopic ureter.[1-3,6-8] The irritation of rubbing from intestinal parasite and/or from vaginal foreign bodies and/or from urinary tract infections may result in inflammation and a secondary skin infection.

Etiologies of sexually transmitted diseases are indicated in *Table 1* and are presumed evidence of abuse.[1-3,6-8] Trichomonas is listed in the differential of premenarchal vulvovaginitis, but it does not generally occur, even if exposed, unless the child is pubertal with some endogenous estrogen production.

Management of nonspecific vulvovaginitis

Once the diagnosis is made, treatment is aimed at the specific cause and may include antibiotics but certainly supportive care. This article discusses the management of nonspecific bacterial vulvovaginitis since it is the most common form. Appropriate treatment is given in *Table 2*. If the vulvovaginitis continues despite this therapy, a more thorough evaluation will be necessary with the potential need for vaginoscopy under anesthesia.

Conclusion

This article has reviewed the evaluation of premenarchal vulvovaginitis including history, exam, etiologies and management of the most common type. Physicians should be able to evaluate, diagnose and treat most cases. ❑

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References

1. Huffman J, et al: *The Gynecology of Childhood and Adolescence.* Philadelphia, Pa: WB Saunders Co; 1981, 121-140.

2. Bacon JL: Pediatric vulvovaginitis. *Adolesc Pediatr Gynecol*, 2:86-93, 1989.

3. Altchek A: Pediatric vulvovaginitis. *Pediatr Clin N Amer*, 19:559-580, 1972.

4. Hermans-Giddens ME, et al: Prepubertal female genitalia: Examination for evidence of sexual abuse. *Pediatrics*, 80:203-208, 1987.

5. Cowell C, et al: The gynecological examination of infants, children, young adolescent. *Pediatr Clin N Amer*, 28:247-266, 1981.

6. Huffman J: Premenarchal vulvovaginitis. *Clin Obstet Gynecol*, 20:543-581, 1977.

7. Heller R, et al: Vulvovaginitis in the premenarchal child. *J Pediatr*, 74:370-377, 1969.

8. Hammerschlag M, et al: Microbiology of the vagina in children: Normal and potentially pathogenic organisms. *Pediatrics*, 62:57-62, 1978.

drug names

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Look-alike and sound-alike drug names can be misinterpreted by a nurse reading doctors' orders or by a pharmacist compounding physicians' prescriptions.

Such misunderstandings can result in the administration of a drug not intended by the prescriber. Awareness of such look-alike and sound-alike drug names can reduce potential errors. ❑

Look-alike and sound-alike drug names

	LONITEN	LOXITANE
Category:	Antihypertensive	Antipsychotic
Brand name:	Loniten, Upjohn	Loxitane, Lederle
Generic name:	Minoxidil	Loxapine
Dosage forms:	Tablets	Capsules, concentrate, injection
	ISMO	**DMSO**
Category:	Antianginal	Urinary tract product
Brand name:	ISMO, Wyeth-Ayerst	Rimso-50, Research Industries
Generic name:	Isosorbide mononitrate	DMSO (Dimethyl sulfoxide)
Dosage forms:	Tablets	Solution

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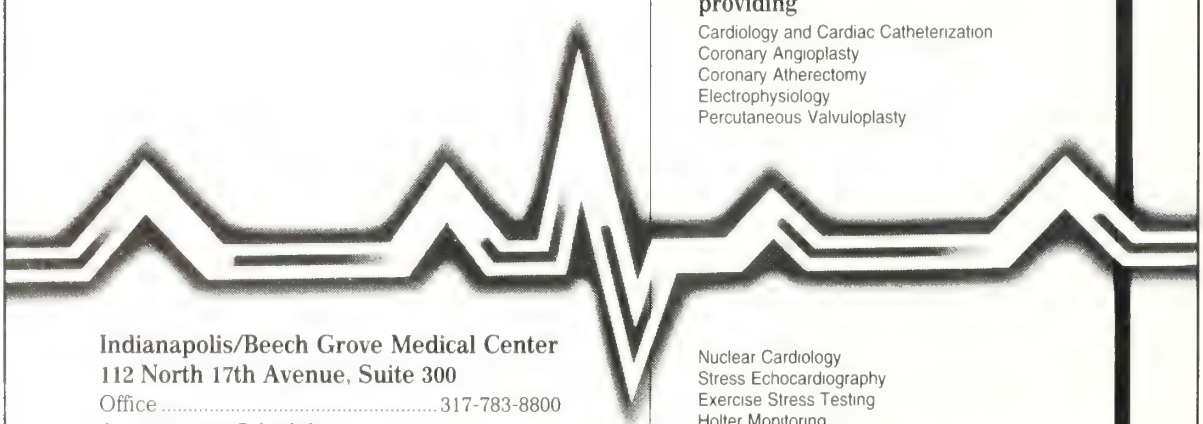
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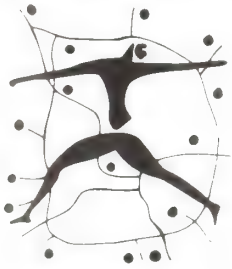
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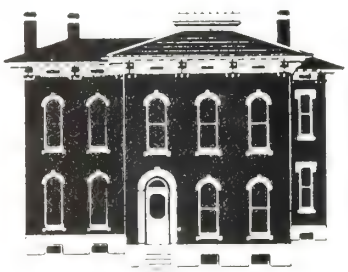
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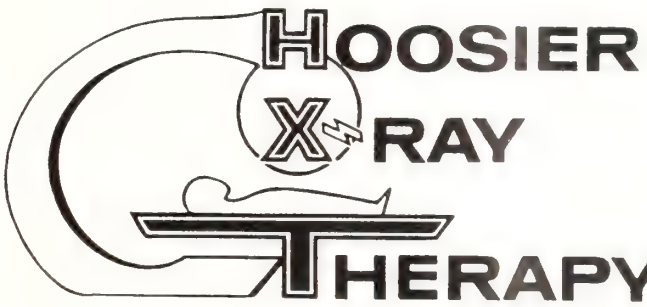
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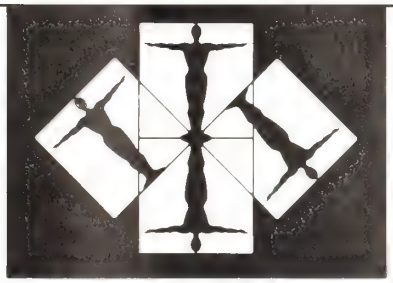
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*2 – Jerome E. Melchior, Vincennes (1993)
3 – Gordon L. Gutmann, Jeffersonville (1994)
4 – Arthur C. Jay, Lawrenceburg (1995)
5 – Fred E. Haggerty, Greencastle (1993)
6 – Ray Haas, Greenfield (1994)
7 – Ronald Blankenbaker, Indianapolis (1995)
7 – John M. Records, Franklin (1993)
7 – Bernard Emkes, Indianapolis (1994)
8 – John V. Osborne, Muncie (1993)
9 – Stephen Tharp, Frankfort (1994)
10 – Frank Sturdevant, Valparaiso (1995)
11 – Jack W. Higgins, Kokomo (1993)
12 – John R. Thomas, Fort Wayne (1994)
13 – Alfred C. Cox, South Bend (1995)
RMS – Clint E. Myers, Indianapolis (1993)
MSS – Paul Forman, Indianapolis (1993)
*Chairman

ALTERNATE TRUSTEES
(Terms end in October)
District
1 – Barney R. Maynard, Evansville (1994)
2 – James P. Beck, Washington (1995)
3 – John H. Seward, Bedford (1995)
4 – Lawrence R. Bailey Jr., Aurora (1994)
5 – Roland M. Kohr, Terre Haute (1994)
6 – Howard C. Deitsch, Richmond (1995)
7 – Frank Johnson, Indianapolis (1994)
7 – Paula Hall, Mooresville (1995)
7 – Ronald Stegemoller, Danville (1993)
8 – Susan K. Pyle, Union City (1994)
9 – Daniel Berner, Lafayette (1995)
10 – Tom Brubaker, Munster (1994)
11 – Laurence K. Musselman, Marion (1995)
12 – Joseph Mantheiy, Bluffton (1995)
13 – Richard J. Houck, Michigan City (1994)
RMS – Carla Brumbaugh, Indianapolis (1993)
MSS – Scott Hollingsworth, Indianapolis (1993)

AMA DELEGATES (Terms end Dec. 31)
Marvin E. Priddy, Fort Wayne (1993)
John D. MacDougall, Beech Grove (1993)
Edward Langston, Indianapolis (1993)
John A. Knote, Lafayette (1994)
Shirley Khalouf, Marion (1994)
George T. Lukemeyer, Indianapolis (1994)

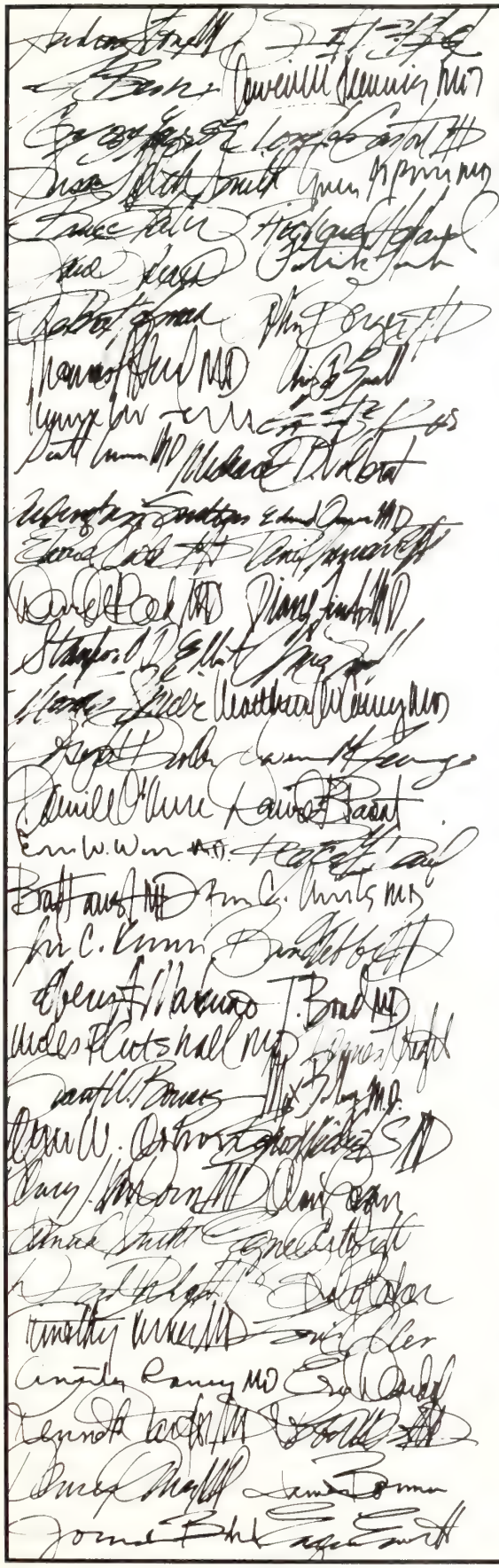
AMA ALTERNATE DELEGATES
(Terms end Dec. 31)
John Thomas, Fort Wayne (1993)
Michael O. Mellinger, LaGrange (1993)
George Rawls, Indianapolis (1993)
Max N. Hoffman, Covington (1994)
C. Dyke Egnatz, Schererville (1994)
Alfred Cox, South Bend (1994)

DISTRICT OFFICERS & MEETINGS
1 - Pres: Gregory Hindahl, Jasper
Secy: Mariellen Dentino, Evansille
Annual Meeting: May 20, 1993
2 - Pres: Bill Vaughn, Vincennes
Secy: Mike Kelly, Vincennes
Annual Meeting: May 13, 1993
3 - Pres: John Norton, Corydon
Secy: Rashidul Islam, New Salisbury
Annual Meeting: May 19, 1993
4 - Pres: Manuel Garcia, Batesville
Secy: David Welsh, Batesville
Annual Meeting: May 5, 1993
5 - Pres: Paul Houston, Brazil
Secy: Rahim Farid, Brazil
Annual Meeting: May 27, 1993
6 - Pres: William Toedebusch, Richmond
Secy: Helen Steussy, New Castle
Annual Meeting: May 12, 1993
7 - Pres: Ronald Stegemoller, Danville
Secy: Craig Moorman, Franklin
Annual Meeting: June 30, 1993
8 - Pres: Gordon M. Hughes, Muncie
Secy: Gerard T. Costello, Muncie
Annual Meeting: June 2, 1993
9 - Pres: Thomas A. Mabel, Noblesville
Secy: Stephen D. Tharp, Frankfort
Annual Meeting: June 9, 1993
10 - Pres: Filemon P. Lopez, Dyer
Secy: Barron M. Palmer, Hammond
Annual Meeting: June 16, 1993
11 - Pres: Brian Doggett, Delphi
Secy: Jack Higgins, Kokomo
Annual Meeting: Sept. 15, 1993
12 - Pres: William Aeschliman, Fort Wayne
Secy: Joseph Mantheiy, Bluffton
Annual Meeting: Sept. 16, 1993
13 - Pres: Michael Deery, Culver
Secy: John W. Schurz, South Bend
Annual Meeting: Sept. 8, 1993

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Adele Lash, *Director of Operations/ Communications*
Mike Abrams, *Director of Marketing/ Legislation*
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from the museum

Oren Cooley
Indianapolis

The trephine, or trepan, that medical practitioners used during the 1800s to remove bone sections from the skull has changed extensively since its conception.

The earliest trepans consisted of a sharp piece of flint or obsidian, which primitive man used to scrape apertures of various sizes in the skull. Performed in conjunction with religious ceremonies, this procedure was believed to create an exit for disease demons or evil spirits.

In ancient civilizations, medical practitioners used trepans in circumstances devoid of ceremonial ritual. The surgeon employed the instrument to relieve headaches, to cut away badly shattered parts of a skull fracture and, later, to reduce the pressure of a hemorrhage or a tumor.

The ancient Greeks initially performed trepanation by using a terebra, a drill that consisted of a sharp-pointed shaft. The surgeon operated the terebra by placing and then turning a thong or bow around this shaft.

With the terebra, the surgeon made small holes in a circle around the piece of bone slated for removal. After completing this phase, the interspace between each hole was broken by a scalpel.

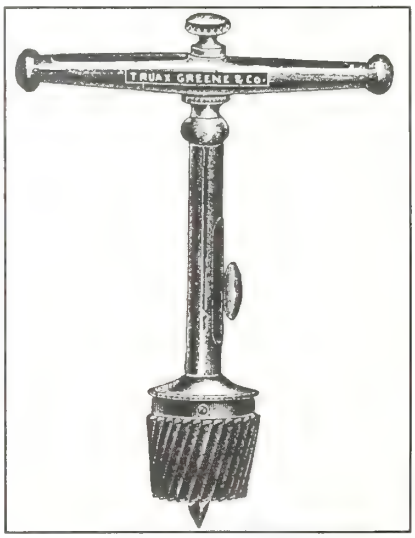
The Greeks devised the terebra serrata, a conical piece of metal with a circular serrated edge at its base. Using the center pin of this instrument to help engage the skull, the surgeon rolled the instrument's cylindrical handle between his palms to cut the circular groove in the skull.

By the 1500s, the trepan consisted of a cylindrical saw affixed to a brace or drill-stock handle, which the surgeon turned in the same manner that a carpenter turned a wimble.

During the late 1500s, the surgeon Fabricius ab Aquapendente (1537-1619) devised the trephine – a trepan on which the handle occurs at right angles to the shaft. The triangular shape that resulted from this configuration provided the new name for this instrument.

In 1798, Savigny, a British company that manufactured medical instruments, described the trephine as "a cylindrical saw with a smooth drum, the barrel of which is inserted into the handle direct." The company's catalog also noted, "The pin has fine teeth with no gaps and runs in a slot in the barrel, being regulated by a binding-screw and plate."

This construction, however, still allowed bone dust to clog the instrument during its operation.



Physicians by the 1800s typically used the trephine to remove bone sections from the skull to reduce the pressure associated with an underlying hemorrhage or brain tumor.

In 1801, Scottish surgeon Benjamin Bell (1749-1806) resolved this problem when he introduced a trephine with teeth arranged in three groups of nine, allowing gaps to prevent clogging.

In the 1800s, the surgeon typically exposed the skull during trephination by opening a flap of the scalp and pushing back the periosteum with a raspatory or scraping instrument. After using a perforator to make a pilot hole, the surgeon then extended the trephine's center pin 1/16 of an inch beyond the instrument's teeth and placed the center pin into the pilot hole.

Rotating the trephine from left to right, the surgeon cut a groove of a sufficient depth to hold the instrument in place and retracted the center pin to prevent damage to the dura mater or other soft tissues. Inward and downward pressure on the trephine's handle was used to complete the incision.

The surgeon, however, experienced difficulty cleaning the trephine with a retractable center pin because blood and other matter could enter the instrument's hollow shaft. Although a trephine that allowed the separation of all its parts existed by the late 1800s, the surgeon typically reserved the trephine for critical cases since the procedure's mortality rate often exceeded 50%. ❑

Sources: *Antique Medical Instruments* (1979) by Elisbeth Bennion; *The History and Evolution of Surgical Instruments* (1942) by Dr. C.J.S. Thompson; and *The Mechanics of Surgery* (1899) by Charles Truax.

Oren Cooley is the director of the Indiana Medical History Museum in Indianapolis. For information, call (317) 635-7329.

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cme calendar

Indiana University

The Indiana University School of Medicine will sponsor these courses:

May 19-20 – 28th Annual Indiana Multidisciplinary Child Care Conference, Omni North Hotel, Indianapolis.

May 20-22 – 1993 Contemporary Issues in Total Hip & Knee Replacement, University Place Conference Center, Indianapolis.

June 11-12 – 76th Annual Meeting and Scientific Seminar of the Indiana Academy of Ophthalmology, University Place Conference Center, Indianapolis.

July 8-17 – 78th Annual Anatomy and Histopathology of the Head and Neck and Temporal Bone, University Place Conference Center, Indianapolis.

July 30-Aug. 1 – Minimally Invasive Surgery and Its Complications, University Place Conference Center, Indianapolis.

Sept. 7-8 – Current Issues in Perinatal Care, University Place Conference Center, Indianapolis.

Sept. 7-11 – Fourth Annual Comprehensive Transthoracic and Transabdominal Fine Needle Aspiration Biopsy Cytology, University Place Conference Center, Indianapolis.

Sept. 24 – Clinical Laboratory Improvement Amendments: How to Play the Game with the New Rules, University Place Conference Center, Indianapolis.

Sept. 30 – Update on Management of HIV Infection, University Place Conference Center, Indianapolis.

For more information, call (317) 274-8353.

Methodist Hospital

Methodist Hospital of Indiana in Indianapolis will sponsor these CME courses:

May 28 – 19th Annual Wishard Lecture, Methodist Hospital, Indianapolis.

June 11-13 – American Fertility Society, Methodist Hospital, Hyatt Regency, Indianapolis.

July 25-31 – Diabetes Mini Fellowship, Happy Hollow Camp for Children, Nashville, Ind.

Aug. 25-31 – ATLS, Methodist Hospital, Indianapolis.

Sept. 18 – Health Care for the Homeless, Indiana Government Center, Indianapolis.

Oct. 8 – Neurology in Primary Care Medicine.

Oct. 30 – Cardiology for the Clinician.

For details, call (317) 929-3733 or 1-800-847-3370.

St. Vincent Hospital

St. Vincent Hospital in Indianapolis will sponsor these CME courses:

May 20 – Special Topics in the Management of HIV-Infected Patients: Half-Day Seminars for Clinicians – ZEBRAS! Unusual Manifestations of HIV Disease, St. Vincent Marten House Hotel and Conference Center, Indianapolis.

May 24-27 – Hernia '93: Advances or Controversies – An International Perspective, Radisson Plaza Hotel, Indianapolis.

For more information, call Beth Hartauer at (317) 338-3460.

University of Michigan

The University of Michigan Medical School will sponsor these courses:

June 9-11 – 11th Annual Laboratory Information System Symposium, Towsley Center, University of Michigan, Ann Arbor, Mich.

July 11-13 – Seventh Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management, Grand Traverse Resort, Mich.

July 22-24 – Advances in Office Psychiatry: Mood and Anxiety Disorders, Grand Traverse Resort, Mich.

Aug. 8-11 – Internal Medicine Update, Grand Hotel, Mackinac Island, Mich.

For more information, call the registrar (313) 763-1400. ❑

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obituaries

Bill E. Freeland, M.D.
Dr. Freeland, 70, an Indianapolis obstetrician and gynecologist, died Jan. 31, 1993, at his home.

He was a 1950 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Freeland started the special care nursery at St. Vincent Hospital in Indianapolis, where he was chief resident from 1968 to 1972. He had an obstetrics and gynecology practice in Indianapolis since 1972. He previously was a general practitioner in Batesville, where he founded the emergency response unit of the volunteer fire department, and was Ripley County coroner for eight years. He was a fellow of the American College of Obstetricians and Gynecologists.

Sprague H. Gardiner, M.D.
Dr. Gardiner, 82, an Indianapolis obstetrician and gynecologist and professor emeritus at the Indiana University School of Medicine, died Feb. 16, 1993, at Indiana University Hospital.

He was a 1934 graduate of the University of Michigan Medical School and an Army veteran of World War II.

Dr. Gardiner was a professor of obstetrics and gynecology at IU from 1946 to 1981, when he retired. He had served as president of the American College of Obstetricians and Gynecologists and chairman of an American College of Surgeons national task force on perinatal care. As the task force chairman, he developed guidelines for the prenatal care of high-risk mothers and newborns, work that was recognized with awards from the American Academy of Pediatrics and the National Foundation, March of Dimes. He served for nine years as an American Medical Association commissioner to the Joint Commission on Accreditation of Hospitals. Dr. Gardiner was appointed by President Richard Nixon as vice chairman of the national commission for the observance of World Population Year in 1974 and was named a Sagamore of the Wabash by then-Gov. Robert Orr in 1985.

Austin L. Gardner, M.D.
Dr. Gardner, 66, a retired Indianapolis vascular surgeon, died Feb. 15, 1993, at his home.

He was a 1952 graduate of the Indiana University School of Medicine and was a Navy veteran of World War II.

Dr. Gardner was in private practice 33 years, retiring in 1992. He was the first staff surgeon at Wishard Memorial Hospital and established the first intensive care unit and renal transplant program there. He was a clinical professor of surgery at the Indiana University School of Medicine, a fellow of the American College of Surgeons, a past president of the Indiana Chapter of the American College of Surgeons and a diplomate of the American Board of Surgery.

Robert B. Hart, M.D.
Dr. Hart, 86, a retired Columbus, Ind., family physician, died Jan. 29, 1993, at Columbus Convalescent Center.

He was a 1934 graduate of the Indiana University School of Medicine.

Dr. Hart had a practice in Hope from 1935 to 1937 before moving his practice to Columbus. He retired in 1978. He was a member of the ISMA Fifty Year Club.

William M. Kendrick Jr., M.D.
Dr. Kendrick, 77, a founder of Kendrick Memorial Hospital in Mooresville, died Feb. 17, 1993, at Methodist Hospital in Indianapolis.

He was a 1941 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Kendrick, who refined new techniques in colon and rectal surgery, was chairman of the board of directors of Kendrick Memorial Hospital and had served as president of Kendrick Management Co. He and his partner, Dr. Kenneth E. Comer, developed a colon and rectal treatment clinic, the Comer-Kendrick Sanitarium, in 1947. When Dr. Comer left, Dr. Kendrick renamed the facility in honor of his mother. In recent years, Dr. Kendrick expanded the hospital's areas of specialties, including hip and knee joint replacement. Dr. Kendrick had also served on the staff at the Indiana University Medical Center and at Methodist, St. Vincent and St. Francis hospitals.

Merritt C. Mauzy, M.D.
Dr. Mauzy, 73, a retired South Bend plastic surgeon, died Jan. 31, 1993, at Memorial Hospital in South Bend.

He was a 1944 graduate of the Indiana University School of Medicine.

Dr. Mauzy, who retired in 1985, was a member of the International Plastic Surgery Society and the Ohio Valley Plastic Surgery Society.

obituaries

David L. Phillips, M.D.
Dr. Phillips, 69, an Indianapolis psychiatrist and former chief of staff at Fairbanks Hospital, died Feb. 21, 1993, at his home.

He was a 1947 graduate of the University of Maryland School of Medicine and an Army veteran of World War II.

Dr. Phillips, who had a private psychiatric practice for 35 years, co-founded the Koala Center in Lebanon. He was a former assistant director of psychiatric education at Norways Hospital and former director of the Private O.P. Psychiatric Center. He also had been a psychiatric consultant at the Christian Theological Seminary, Kairos Center for the Family, Human Services Counseling Center, Courageous Living Counseling Center and RMS-Group Homes for the mentally retarded. Dr. Phillips was certified by the American Board of Psychiatry and Neurology and was a life fellow of the American Psychiatric Association.

Ralph Wilson, M.D.
Dr. Wilson, 88, a retired Evansville surgeon, died Feb. 4, 1993, at Gertha's Nursing Center in Evansville.

He was a 1929 graduate of the Indiana University School of Medicine.

Dr. Wilson retired in 1982 after 53 years in practice. He was the third generation of his family to practice medicine. While doing graduate work in surgery at the University of Pennsylvania, he became a professional wrestler known as "The Masked Marvel" and later as "The Flying Surgeon." He wrestled several times in Madison Square Garden in New York.

Ralph H. Young, M.D.
Dr. Young, 89, a retired Goshen physician, died Jan. 26, 1993, at his home.

He was a 1928 graduate of the Indiana University School of Medicine.

Dr. Young, a native of Huntington, had a medical practice in Goshen from 1929 until his retirement in 1988. During that time, he delivered more than 3,000 babies. He was a member of the Goshen Rotary Club for more than 50 years. ❑

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about the artist

Indianapolis artist portrays people in urban settings

Stephen Stoller's painting titled "Wheeler Mission Library" that appears on this month's cover of INDIANA MEDICINE is the culmination of five months' work at the mission for the homeless in downtown Indianapolis.

Before painting the final canvas in his studio, Stoller made smaller individual sketches – 50 drawings and 17 paintings – of the people who regularly visit the mission for meals and a bed for the night. He wanted his final work to show the regular mission visitors and "to represent the full composition of the situation," but the mission library did not offer a suitable vantage point.

Since Stoller had already painted scenes of the outside of Wheeler Mission, he had become acquainted with some of the mission visitors and earned their trust. "My responsibility is to honor and ennoble my subjects," he says.

One reason he enjoys representing the homeless is because they have suffered so much heartache and trouble that they have dropped all sense of pretension, he says. "They're not worried about the vanities of life," he says. "I can paint them more candidly." Because he and his wife, Francy, had once been homeless for a few months, he also is able to better understand their circumstances.

Stoller has been a street painter for 12 years, depicting in oil people in urban settings, including not only the homeless but people at bus stops and utility repairmen on the job, for example. Before moving to Indianapolis 10 years ago, he had lived and worked in New York (his home), Chicago, Atlanta and Quebec.

Stoller is known for his mural-size paintings. The Wheeler Mission painting measures about 6 feet, 5 inches by 5 feet. His painting titled "Etheridge Knight Free People's Poetry Workshop" dominates the second floor landing of the main stairwell at the Indiana State Museum in Indianapolis. His most recent work, "Children of Somalia," stretches almost the width of his gallery, Denouement Fine Art, 413 Massachusetts Ave., Indianapolis.

The Somalia painting will be on display during an exhibition that opens in May at his gallery. Painted based on his impression of newspaper and television pictures of the starving African children, the work attempts to show the spiritual enlightenment he perceives in them, he says. Despite the fact that these children "live a step away from death," they keep a tremendous hope, he believes.

A self-taught artist who received most of his training through working in art, Stoller also sculpts in marble and limestone. He and his wife, a poet, have six children. ❑

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In 1993, Physicians Insurance Company of Indiana (PICI) begins its second decade of leadership in medical professional liability insurance and related services.

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In many respects, PICI has exceeded the expectations of the ISMA leaders who participated in its formation. PICI has brought to all Indiana physicians coverage concepts and service features not previously available (physician consent to settle clause, premium discounts for young physicians, risk management services, etc.). As PICI keeps pace with rapid changes in the practice of medicine and the total health care industry, other insurers are challenged to do so, as well. This is where PICI's leadership is so vital to our entire membership.

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I.S.M.A.

The ISMA Task Force on the ISMA/PICI Partnership will keep you informed about our celebration of PICI's Second Decade of Leadership. We hope you will take full advantage of all opportunities to participate.

On behalf of the leadership and staff of both the ISMA and PICI, thanks for your continued interest and support.



William H. Beeson, M.D.

William H. Beeson, M.D.
President, ISMA



John MacDougall

John MacDougall, M.D.
Chairman of the Board, PICI

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news briefs

Center for rural health opens in Terre Haute

The family practice residency program at Union Hospital in Terre Haute has created the Midwest Center for Rural Health. The center was established to help alleviate the shortage of family practice physicians in rural areas.

"We've found through the years with our family practice residency that if you provide training and education specifically about rural practice realities, more residents are interested in practicing in rural communities, and they are much more likely to remain practicing in rural communities over the long run," said James Buechler, M.D., director of the residency program.

The MCRH features a rural track curriculum that second-year residents can elect to take. This training track provides on-site education through preceptorships with rural physicians and experiences in hospitals and county health and mental health departments. Residents also will receive special training in procedural medicine as it pertains to rural family practice. Five residents will join the residency program this year; nearly all are expected to select the rural training track.

A model rural training site is being established that will create an opportunity for the MCRH to fulfill a medically underserved community's need for medical care while allowing for experimentation with alternative management systems for the rural practice. These systems can include the introduction of nurse practitioners and physician assistants to the community and the rotation of residents through the site to help alleviate staffing constraints.

Future plans for the center include serving as a regional resource for information and research about rural health issues and a place to solve specific health concerns of rural people.

Butler anthropologist studies effects of organ transplants

A Butler University professor has been conducting research on "Personhood and the Bioethics of Organ Transplantation," or how transplants alter a patient's sense of self and others' perceptions of them.

Lesley Sharp, a socio-cultural anthropologist, has found that patients identify with their donor. She said patients develop a bond with the donor, even though they've never met. She is studying all those involved in the transplant process, including doctors, nurses, the procurement team, transplant social workers, patients, families, potential donors and hospital chaplains. She has obtained most of her data in Indianapolis.

Indiana Heart Institute defining cardiac standards

The Indiana Heart Institute at St. Vincent Hospital in Indianapolis is joining other top cardiac programs to develop plans to define national standards and procedures for cardiac care. The institute is a member of the National Cardiovascular Network, which involves more than 40 cardiac programs. The goal is to provide quality services in a consistent and cost-effective manner.

The institute is a partnership between St. Vincent Hospitals and three Indianapolis cardiac physician groups: Nasser, Smith & Pinkerton Cardiology; Northside Cardiology; and Shumacker, Isch, Jolly, Fitzgerald, Fess and Glasser M.D.s Inc.

Conference on aging face attracts 200 physicians

Two hundred physicians from the United States, Germany, Brazil and Croatia attended the Aesthetic Surgery of the Aging Face course in Indianapolis.

William Beeson, M.D., an Indianapolis facial plastic surgeon was the course director and moderated seminars on dorsal hump reduction, phenol peels, foreheadplasty and rhytidectomy posterior neck dissection and management of the deep cervical fascia. Other faculty included Henry Baylis, Clyde Litton, Many Marritt, Ivo Pitanguy, Allen Putterman and Harold Brody.

The course was sponsored by Beeson Facial Plastic & Reconstructive Surgery in Indianapolis and the American Academy of Facial Plastic and Reconstructive Surgery. Attendance at the 1993 course was triple that of previous years.

Fall symposium to focus on pediatric surgery

"Advances in Pediatric Surgery: A Course for Pediatricians and Family Practitioners" is the focus of a symposium to be held Sept. 28 at University Place Conference Center and Hotel in Indianapolis.

The CME course is sponsored by the Section of Pediatric Surgery, Department of Surgery, Indiana University School of Medicine and Riley Hospital for Children. For information, call Sandy Davis, (317) 274-4681.

State physicians involved in research on angioplasty

Physicians at the Indiana Heart Institute at St. Vincent Hospital in

Indianapolis played a key role in a national study that found reopening clogged coronary arteries with balloon angioplasty saves more lives than the widely used method of injecting clot-dissolving drugs. The research was released in the March 11, 1993, issue of the *New England Journal of Medicine.*

Cardiologist Donald Rothbaum, M.D., of Northside Cardiology was a primary author of this study. Other Indiana Heart Institute and Northside Cardiology physicians also were involved.

Hoosier Oncology Group cited for recruiting

The Hoosier Oncology Group (HOG), a statewide organization of cancer physicians and nurses, had been cited for its success in recruiting a select group of women in Indiana and surrounding states into the largest breast cancer prevention study ever.

HOG member institutions rank fourth among 118 participating centers consisting of 270 branches in the United States and Canada.

Sponsored by the National Cancer Institute, the study is following 16,000 women at risk for breast cancer to see whether the drug Tamoxifen is effective in preventing cancer as well as heart disease and osteoporosis.

Regenstrief Institute names new directors

The Regenstrief Institute for Health Care Policy in Indianapolis has named new directors. Co-directors of the 25-year-old institute are Indiana University School of Medicine faculty members Clement J. McDonald, M.D., distinguished professor of medicine, and Charles Clark, M.D., professor of medicine and pharmacology and toxicology.

The mission of the institute is to investigate methods to increase the efficiency of health care delivery while finding ways to reduce costs. Half of the institute's budget is funded by the Regenstrief Foundation, and the rest comes from research grants and contracts directed by I.U. faculty who make up the investigators of the institute.

Nutrition for people with AIDS focus of booklet

The Physicians Association for AIDS Care (PAAC) and Stadtlanders Pharmacy have published a 21-page booklet titled *HIV Disease Nutrition Guidelines: Practical Steps for a Healthier Life.* The booklet offers easy-to-follow nutritional recommendations for people living with HIV/AIDS. Subjects include planning a balanced diet, specific nutrients that enhance the immune system, food safety, the importance of exercise and stress management in maintaining health, and eating to combat symptoms such as nausea, fatigue and diarrhea.

To obtain a free copy of the booklet, call Stadtlanders Pharmacy at 1-800-238-7828 or write to Stadtlanders Pharmacy at 600 Penn Center Blvd., Suite 700, Pittsburgh, PA 15235. ❑

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Dr. William H. Beeson, an Indianapolis plastic and reconstructive surgeon, received the first President's Leadership Award from the American Academy of Cosmetic Surgery. The award is given for distinguished achievement and significant contributions to cosmetic surgery. He also is in the process of publishing two books, *Developing a Practice in Ambulatory Surgery* and *Facial Plastic Surgery Clinics of North America: Facelifts.*



Dr. Schauwecker

Dr. Donald S. Schauwecker, a specialist in nuclear medicine at Wishard Memorial Hospital in Indianapolis, has been installed as treasurer of the American College of Nuclear Physicians (ACNP). He also has served on several ACNP committees.

Dr. A. Michael Sadove, an Indianapolis plastic surgeon, was the course director for the Advances in Craniomaxillofacial Surgery course in Indianapolis, sponsored by the Indiana University School of Medicine. He presented a seminar on "Microplate Fixation in Head and Neck Reconstruction."

Dr. William Rate and **Dr. Peter Garrett**, both of Methodist Hospital in Indianapolis, presented papers at the Fourth International Symposium on Intraoperative Radiation Therapy in Munich, Germany. Dr. Rate presented a paper titled "Surgical Resection and Intraoperative Radiation Therapy for Advanced Neck Lymphoid Metastases." Dr. Garrett presented a paper on "Surgical Resection and Intraoperative Radiation Therapy for Advanced or Recurrent Salivary Gland Malignancy" and served as chairman of the session on brain and head and neck tumors.

Dr. Don B. Ziperman, chairman of the cardiology department of Community Hospitals Indianapolis, was elected to fellowship in the American College of Physicians.

Dr. Bradley A. Weinberg, a cardiologist with Indianapolis Cardiology Associates, co-authored an article titled "Five Year Follow-Up of 589 Patients Treated with Amiodarone" in the January 1993 issue of *American Heart Journal.*

Dr. Timothy A. Goedde, an Indianapolis surgical oncologist, developed a flier promoting breast cancer awareness that was distributed at a recent Indiana Pacers game. The project was in conjunction with The Pacer Connection, a group of Pacer wives who are promoting the early detection of breast cancer.

Dr. Stephen W. Perkins, an Indianapolis facial plastic and

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

January
Bermudez-Webb, Nini M., Indianapolis
Bolinger, Garry L., Indianapolis
Castor, Conrad P., Schererville
Dolembo, John M., Indianapolis
Fischer, Charles K., Evansville
Galup, Luis N., South Bend
Garber, John E., Indianapolis
Harris, James C., Indianapolis
Hogan, Michael A., Indianapolis
Kight, Jerry L., Indianapolis
Mattox, Dean L., Angola
Melchior, Jerome E., Vincennes
Schaffer, Jeffrey L., LaPorte
Schalliol, James P., Rochester
Siebenmorgen, Paul, Terre Haute
Vorwald, Mary J., Zionsville
Wagner, Lindley H., Lafayette
Wass, Justin L., Indianapolis
Welk, Gordon D., Rossville
White, Wayne B., Connersville
Zehr, Brian P., Fort Wayne

February
Ansari, Mohammad A., Muncie
Black, Kenneth A., Portage
Booze, James H., Bloomington
Branco, Arthur M., Schererville
Chung, Tae S., Vincennes
Deschner, William P., Fort Wayne
Dhar, Sisir K., Terre Haute
Gunderson, Shaun D., Goshen
Hughes, Charles E., Beech Grove
Levine, Michael D., Carmel
Masbaum, Ned P., Indianapolis
Records, John M., Franklin
Rougraff, Maurice E., Noblesville
Saalwaechter, John J., Lebanon
Stork, Leslie F., Munster
Walters, Daniel A., Seymour
Weinberg, Howard J., Munster
Wilson, Franklin D., Indianapolis

reconstructive surgeon, spoke at several recent seminars. He discussed scar revision and dermabrasion at the Soft Tissue Surgery Conference at the Indiana University Medical Center and spoke on "Preoperative Evaluation, Selection and Techniques for Chemical Peel" at St. Louis University. The topic of his presentation to the St. Louis ENT Society was "The Management of Complications of Chemical Peel." He was a panelist for discussions on "Complex Nasal Tip Problems in the Aging Patient" and "Ancillary Procedures and Blepharoplasty" at the course on Aesthetic Surgery of the Aging Face sponsored by the American Academy of Facial Plastic and Reconstructive Surgery. He discussed chemical peel at the meeting of the Florida Society of Dermatologic Surgery.

Dr. Frederick M. Kelvin, a radiologist at Methodist Hospital in Indianapolis, spoke on "Barium Examination of the Small and Large Bowel" at St. Louis University Medical Center. He presented a program on "Evaluation of Anorectal Dysfunction" at the annual meeting of the Society of Gastrointestinal Radiologists in Scottsdale, Ariz.

Activities of physicians from Orthopaedics Indianapolis include the following: **Dr. Terry R. Trammel** presented a program on "Rogozinski Lumbar Spinal Instrumentation: Preliminary Results of 108 Patients" at the First Annual Symposium on Advanced Techniques in Spinal Instrumentation, held in New York. **Dr. Michael F. Coscia** co-authored the study. **Dr. D. Kevin Scheid** conducted a case study titled "A Method of Intraoperative Localization of Osteoid Osteoma of the Femoral Neck," published in the November 1992 issue of *Journal of Bone and Joint Surgery*.

Dr. Peter R. Foster of Midwest Heart Associates in Indianapolis and **Dr. Lawrence E. Gering** of Nasser, Smith & Pinkerton Cardiology in Indianapolis have been board certified in clinical cardiac electrophysiology by the American Board of Internal Medicine.

Dr. James W. Strickland of the Indiana Hand Center in Indianapolis was elected second vice president of the American Academy of Orthopaedic Surgeons. He is slated to become president in 1995-1996.

Dr. Richard C. Rink, chief of pediatric urology at Riley Hospital for Children in Indianapolis, was elected president of the American Association of Pediatric Urologists. He will serve a two-year term beginning in January 1994.

Dr. Maurice Arregui, an Indianapolis surgeon, spoke on "The Role of Ultrasound in the Diagnosis of Abdominal Wall and Groin Hernias" and "Laparoscopic Hernia Repairs, Complications and Their Management" at the Hernia 2000 course in Sydney, Australia. He also spoke at the Third International Course of Laparoscopic Surgery in Goianias-Goias, Brazil; his topics were "Laparoscopic Splenectomy," "The Role of ERCP in the Era of Laparoscopic Cholecystectomy" and "Laparoscopic Inguinal Hernia Repairs." During both meetings, he demonstrated with live surgical procedures.

Dr. Robert L. Forste, a Columbus orthopaedic surgeon, has been elected chief of staff at Columbus Regional Hospital. **Dr. G. Daly Walker**, a Columbus surgeon, is the chief of staff-elect.

Several Indiana ophthalmologists recently traveled to Honduras with the Volunteers for Optometric Service to Humanity and Lions Club to set up temporary eye clinics for the needy. They included **Dr. Richard Boling** of Elkhart, **Dr. Dan Krach** and **Dr. J. Rex Parent** of Fort Wayne and **Dr. Derek Sprunger** of Indianapolis. The doctors worked in Tegucigalpa and Comayagua.

Dr. Robert P. Hooker has been elected chief of staff of Hendricks Community Hospital; he is staff pathologist for the hospital and medical director of the laboratory.

Dr. George M. Buehler Sr. has retired after 43 years as a Jeffersonville family physician.

Dr. David B. Goldenberg, chief of radiology, has been elected president of the Hancock Memorial Hospital medical staff.

Dr. G. David Beiser, a Valparaiso cardiologist, has been elected chief of staff at Porter Memorial Hospital.

Dr. Alvan Eller, a Flora family physician, was appointed to the lay advisory council of St. Elizabeth Hospital Center in Lafayette.

Dr. Lee McKinley, a specialist in critical care medicine, has been elected chief of staff at Bloomington Hospital. **Dr. Brandt Ludlow**, an obstetrician/gynecologist, was elected chief of staff-elect.

Dr. Joseph Sala and **Dr. Walter Sala**, brothers who shared family practice offices in Gary and later moved to Merrillville, have retired; they practiced together for half a century.

Dr. James E. Hansen, a Terre Haute neurosurgeon, was elected to the Union Hospital Foundation's board of directors.

people

Dr. James P. Poirier, a Loogootee general practitioner, was appointed to the board of Memorial Hospital and Health Care Center in Jasper. He also was appointed to the Indiana Division of the American Cancer Society Board of Directors.

Dr. Wallace A. Scea, an Elwood family physician, was honored by the Mercy Hospital Governing Board with an etched photographic plaque that will be displayed in the hospital. He was recognized for his service to patients and the community.

Dr. William E. Marcrum, a Tell City family physician, received the distinguished service award from the Tell City Jaycees.

Dr. Joe G. Conley, a New Albany radiation oncologist, received the American Cancer Society's St. George Medal in recognition of his volunteer work for the society. Dr. Conley, who has served three terms as president of the ACS Indiana division, is responsible for recruiting many physicians into the ACS and for persuading more than 100 facilities in the state to provide free or low-cost mammograms.

Dr. Kent W. Erb, a Sheridan family physician, and **Dr. Howard Luginbill**, a retired Indianapolis psychiatrist, were among a group of people from the United States that visited Russia for three weeks at the invitation of Russia's Department of Education. Their mission was to help school teachers develop a curriculum titled Christian Ethics and Morals in Today's Society.

Dr. Paul M. Waitt, a Noblesville surgeon, received the Physician Distinguished Service Award from Riverview Hospital in Noblesville.

Dr. William E. Fitzkee, an Albion family physician, was selected nationally as a representative of rural physicians for a study by the Harvard School of Public Health. The study will focus on the relative complexity of certain medical, surgical procedures and services for over 25 years of service.

Dr. John E. Joyner, an Indianapolis neurosurgeon, was honored at the Living Legends in Black awards banquet. He and seven other black men were honored for their contributions to the black community.

Dr. David W. Zauel, a Greencastle ophthalmologist, recently retired from the U.S. Army Reserves after 21 years of service.

Dr. William C. Schafer retired after 43 years as a Washington, Ind., otolaryngologist.

Dr. Martin Schmidt, a Terre Haute gastroenterologist, was elected to the Union Hospital board of directors.

Dr. Robert D. Arnold, an Indianapolis obstetrician/gynecologist, recently delivered his 17,144th baby, making it his final delivery. Although he is continuing his office practice in gynecology and women's health care, he has stopped delivering babies. ❑

New ISMA members

Rashmi R. Abhyankar, M.D., Terre Haute, family practice.

Zahid Akram, M.D., Terre Haute, pulmonary diseases.

Candice S. Anderson, M.D., Munster, family practice.

Lolita O. Ang, M.D., Schererville, psychiatry.

Nieves C. Antonio, M.D., New Albany, anesthesiology.

Mark C. Arvin, M.D., Lafayette, radiology.

Rebecca B. Brewer, M.D., Bloomington, obstetrics and gynecology.

Robert L. Burke, M.D., Valparaiso, orthopaedic surgery.

William T. Campbell, M.D., Bloomington, anesthesiology.

William D. Carroll, M.D., Bloomington, internal medicine.

Jacob M. Chacko, M.D., Anderson, anesthesiology.

Mario B. Cimafranca, M.D., New Albany, anesthesiology.

Carl D. Coppola, M.D., New Albany, otolaryngology.

Emma C. H. Coronel, M.D., Jeffersonville, anatomic/clinical pathology.

Daniel S. Cotton, M.D., Columbia City, internal medicine.

Mark D. Crowley, M.D., LaPorte, cardiovascular diseases.

Ronald P. Danis, M.D., Indianapolis, ophthalmology.

Joseph R. Decamp, M.D., Fort Wayne, diagnostic radiology.

Dolph M. Denny, M.D., Jeffersonville, cardiovascular diseases.

Judith A. Deutsch, M.D., Indianapolis, infectious diseases.

Shashidhar Divakaruni, M.D., Munster, cardiovascular diseases.

Todd M. Dudley, M.D., Indianapolis, internal medicine.

Anthony K. Duncan, M.D., Louisville, Ky., diagnostic radiology.

Rosalina M. Dy, M.D., LaPorte, anatomic/clinical pathology.

William W. Fedoriw, M.D., Fort Wayne, pediatrics.

Steven E. Fisher, M.D., Fort Wayne, orthopaedic surgery.

Douglas R. Flint, M.D., Indianapolis, family practice.

Sharon F. Hoover, M.D., Muncie, ophthalmology.

Stephen H. Garry, M.D., Lafayette, emergency medicine.

Lawrence L. Geller, M.D., Jeffersonville, urological surgery.

Souheil F. Haddad, M.D., Bloomington, neurological surgery.

Elizabeth L. Hamilton-Byrd, M.D., Indianapolis, neurology.

Karen S. Heard, M.D., Indianapolis, internal medicine.

B. Matthew Hicks, M.D., Fort Wayne, orthopaedic surgery.

Raymond H. Holderman, D.O., Olympia Fields, Ill., family practice.

David A. Hornback, M.D., South Bend, radiation oncology.

Steven T. Hugenberg, M.D., Indianapolis, rheumatology.

Joseph M. Hunt, M.D., Danville, diagnostic radiology.

Paul Jennings, M.D., Goshen, orthopaedic surgery.

Janie L. Jones, M.D., North Vernon, family practice.

Miles J. Jones, M.D., LaPorte, anatomic/clinical pathology.

Robert R. Jones, M.D., Fort Wayne, ophthalmology.

Timothy J. Kelly, M.D., Indianapolis, otolaryngology.

Charles F. Kemper, M.D., Jeffersonville, pediatrics, allergy.

Kurt Kessler, M.D., Jasper, general surgery.

Sang H. Kim, M.D., Muncie, ophthalmology.

Seung Soo Kim, M.D., Fort Wayne, anatomic/clinical pathology.

David H. Kindred, M.D., Lafayette, obstetrics and gynecology.

Joseph A. King, M.D., Rochester, anesthesiology.

Gary S. Kipp, M.D., Jasper, obstetrics and gynecology.

Ronald F. Kloc, D.O., Munster, anesthesiology.

Charles L. Lawler, M.D., LaPorte, internal medicine.

Mark E. Lemmons, M.D., Greenfield, family practice.

Myron I. Lewyckyj, M.D., Valparaiso, ophthalmology.

Barbara Mansmann, M.D., New Albany, pediatrics.

Keith W. March, M.D., Lafayette, family practice.

Sue A. Maurer, M.D., Fort Wayne, obstetrics and gynecology.

Bette G. Maybury, M.D., Indianapolis, neurology.

Mitchell Mazurek, M.D., Fort Wayne, physical medicine and rehabilitation.

Mary R. McCullough, M.D., Greensburg, family practice.

Norman A. Miller, M.D., Jeffersonville, internal medicine.

James R. Milstead, M.D., Frankfort, emergency medicine.

Aijaz M. Mirza, M.D., Wabash, orthopaedic surgery.

Jeffrey P. Myers, M.D., South Bend, obstetrics and gynecology.

Mark A. Nelson, M.D., LaPorte, gastroenterology.

Paul B. Nelson, M.D., Indianapolis, neurological surgery.

Hema U. Patel, M.D., Indianapolis, neurology.

Christopher D. Prevel, M.D., Carmel, plastic surgery.

Christopher J. Quinn, M.D., Granger, family practice.

Jyethirmai K. Reddy, M.D., Fort Wayne, obstetrics and gynecology.

Gene K. Richard, M.D., Fort Wayne, anatomic/clinical pathology.

Ralph W. Richter Jr., M.D., East Chicago, hand surgery.

Christopher P. Rocco, M.D., Anderson, neurology.

Karen L. Roos, M.D., Indianapolis, neurology.

Bruce T. Rougraff, M. D., Indianapolis, orthopaedic surgery.

Vicenta A. Salanova, M.D., Indanapolis, neurology.

Dan A. Sapir, M.D., Lafayette, anesthesiology.

Steven M. Schneider, M.D., Fort Wayne, psychiatry.

Thomas L. Schumann, M.D., Evansville, occupational medicine.

Malavalli N. Seetharam, M.D., Indianapolis, pediatrics.

Erin C. Snyder, M.D., New Albany, family practice.

Eric W. Stark, M.D., Lafayette, anatomic/clinical pathology.

Henry A. Stiene, M.D., Indianapolis, orthopaedic surgery.

Dennis L. Streeter, D.O., Merrillville, general surgery.

Rudolf W. Taubner, M.D., Lafayette, neurology.

Phillip D. Toth, M.D., Indianapolis, internal medicine.

William W. Turner Jr., M.D., Indianapolis, general surgery.

Belinda J. Watts, M.D., Indianapolis, internal medicine.

Roger F. West Jr., M.D., Indianapolis, anesthesiology.

James A. Westervelt, M.D., Jeffersonville, general surgery.

Jon N. Winther, M.D., Fort Wayne, emergency medicine.

Shahnour Yaylayan, M.D., Michigan City, child psychiatry.

Dennis K. Zawadski, M.D., Yorktown, pulmonary diseases.

Kert Zijlstra, M.D., Fort Wayne, gastroenterology.

Residents

Daniel D. Feeney, M.D., Indianapolis, obstetrics and gynecology.

Sheila M. Gamache, M.D., Indianapolis, cardiovascular diseases.

Judy M. Jackson, M.D., Indianapolis, radiation oncology.

Michael G. Khamis, M.D., Indianapolis, radiology.

Dallas E. Peak, M.D., Indianapolis, emergency medicine. ❑

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Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin, the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin.* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol. Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12h}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* (1 hour prior to PRAVACHOL), *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chononic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chononic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Hardenan gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimunum* or *Escherichia coli*, a forward mutation assay in L5178Y TK +/− mouse lymphoma cells, a chromosomal aberration test in hamster cells, and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter^2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated, adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug.

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, ano, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma, anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

(J4-422A)

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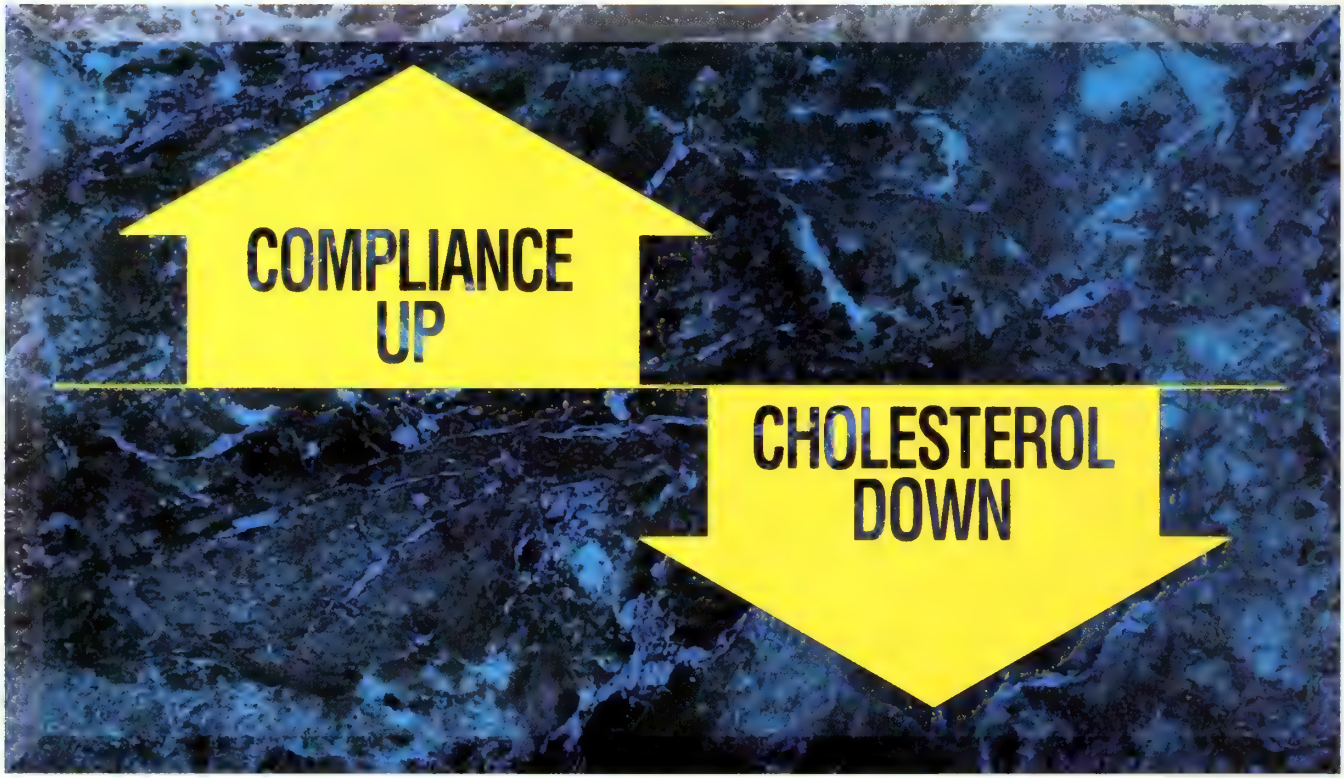
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YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

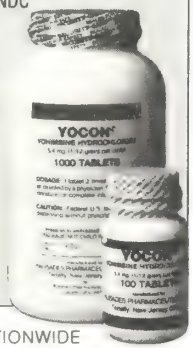
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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National leaders in health care reform to speak at ISMA convention

National authorities in health care reform will participate in a forum during the 1993 ISMA Annual Convention. The panel discussion of national leaders is scheduled from 10 a.m to 1 p.m. Saturday, Oct. 16, and will be followed by a health reform reaction panel, composed of representatives of consumer groups, from 3 p.m. to 5 p.m.

Invited panelists include Gov. Howard Dean, M.D., of Vermont; Gov. Roy Romer of Colorado; Ira Magaziner, senior policy director of the Clinton administration health system task force; Richard Davidson, American Hospital Association; Steven Schroeder, M.D., the Robert Wood Johnson Foundation; Uwe Reinhardt, Princeton University; James Todd, M.D., American Medical Association; and Lynn Etheridge, formerly of the Jackson Hole Group. At press time, Dr. Todd and Etheridge had confirmed that they would participate.

This year's convention will be held Oct. 15 to 17 at the Westin Hotel in downtown Indianapolis. Sheilah Kast, an ABC News business and economics correspondent, will speak at the IMPAC luncheon, set for 1 p.m. Oct. 16. Luncheon tickets are $15.

The President's Night reception and dinner, featuring the music of The Five Easy Pieces, will be held Oct. 16. Tickets are $50 per person in advance or $55 at the door.

ISMA members who do not receive a convention brochure but are interested in attending the health care forum, the IMPAC luncheon or President's Night should complete and return the registration form on page 353 of this issue.

The deadline for submitting resolutions to Janice Herring at the ISMA for consideration by the 1993 House of Delegates is Aug. 16.

Physicians must provide OSHA refresher course for employees

This spring marked the one-year anniversary for implementation of the Occupational Safety and Health Administration (OSHA) regulations on bloodborne pathogens. Physicians are required to provide their staff members with an annual refresher course on the regulations.

Physicians themselves are not subject to training and review requirements unless they are designated "employees" of an organization, nor are they required to take a special test on the regulations. Physicians are required to review and update their practice compliance plans at least annually or whenever a procedure that would expose employees to possible hazard is added to the list of procedures performed by the practice.

The ISMA will present a workshop on OSHA regulations Sept. 1 in Merrillville and Sept. 8 in Indianapolis. For more information, call Barbara Walker or Jan Hubbard at the ISMA, (317) 261-2060 or 1-800-257-4762. ❑

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guest editorial

Improvements in health care

Philip H. Abelson

In efforts to contain costs of health care, all aspects of the complex system should be scrutinized. Obvious savings could be achieved in many facets. A reduction of punitive awards in malpractice suits would lead to a reduction in the number of costly defensive clinical tests and referrals. One potential objective that should be approached cautiously is cost reductions for pharmaceuticals. Expenditures for these constitute about 7% of funds devoted to health care. In contrast, pharmaceuticals have been responsible for about half of the improvement in health care that has occurred during this century. In this period, life expectancy increased from about 50 to 76 years, and extent of pain and suffering was reduced. In the future, life span may or may not be increased much more. But prospects are excellent that pain and suffering will be diminished, and maladies attendant to aging will be ameliorated. Again, about 50% of improvements in health will be due to new drugs. Central to this expectation are the advances being made in genetics and molecular biology. These are providing means of identifying causes and mechanisms of diseases and clues as to how best to deal with them. Much of the relevant knowledge involves recombinant DNA, genes, and detailed information about functions and three-dimensional structures of proteins.

Biotechnology has created a new era in drug development. Earlier advances based on discovery of antibiotics were followed by a trial-and-error approach in which countless thousands of natural products and synthetic chemicals were tested. During that era, the easy-to-discover drugs were found. It is now more difficult than formerly to create a new pharmaceutical, but the knowledge base and experimental approaches have been vastly improved. A stream of new drugs based on biotechnology is now on, or approaching, the market. As many as 16 of these new pharmaceuticals have been approved by the U.S. Food and Drug Administration, and more than 130 are undergoing clinical testing. Targets for further progress include cancer, Alzheimer's disease, cardiovascular disease and AIDS.

Newly created biotechnology companies were pioneers in the present era of drug development. They have been particularly effective up to a point. They have mobilized highly trained teams that have worked long hours and imaginatively to identify new potential pharmaceuticals. They have been motivated by a desire to relieve human suffering. They have also hoped to reach the pot of gold at the end of the rainbow. That journey typically requires 12 years, the expenditure of large sums of money and experiencing many triumphs and disappointments along the way.

On average, the time course of research and development (R&D) for a drug includes three and a half years for laboratory and animal studies, one year for phase one clinical safety studies, two years for phase two clinical effectiveness studies, three years for phase three extensive clinical testing and two and a half years for review by the FDA.

In the three-and-a-half-year initial phase of drug development, costs were limited and the researchers often were content with small pay. Venture capitalists provided funds. But clinical trials are expensive, and phase three usually involves 1,000 to 3,000 patients. To meet the major costs requires large-scale financing. During the interval from July 1990 to July 1991, biotechnology companies received about $2.6 billion from external financing sources. Given a continuation of the present climate of price pressure on pharmaceutical companies, it is doubtful that adequate funds could be raised in the stock market or elsewhere. There now exists a substantial hazard of cessation of clinical tests, further demoralization of staffs of the biotechnology companies, and the disappearance of companies, some of them to be swallowed by the large traditional firms.

The major pharmaceutical companies have enjoyed a substantial period of prosperity and could withstand some trimming of their income. One estimate is that their profit margin is 13%. This translates into a profit of about $10 billion on sales of $76 billion. In 1992, the companies spent about $12.6 billion on R&D. If profit margins were reduced, the major firms would survive. They would probably respond to a smaller net profit as have those in other industries by chopping R&D. The major casualties of excessive price pressure on drugs would be the small biotechnology companies, the rate of development of new drugs to relieve human suffering and global leadership of the United States in creating new pharmaceuticals. ❑

The author is a deputy editor of Science.

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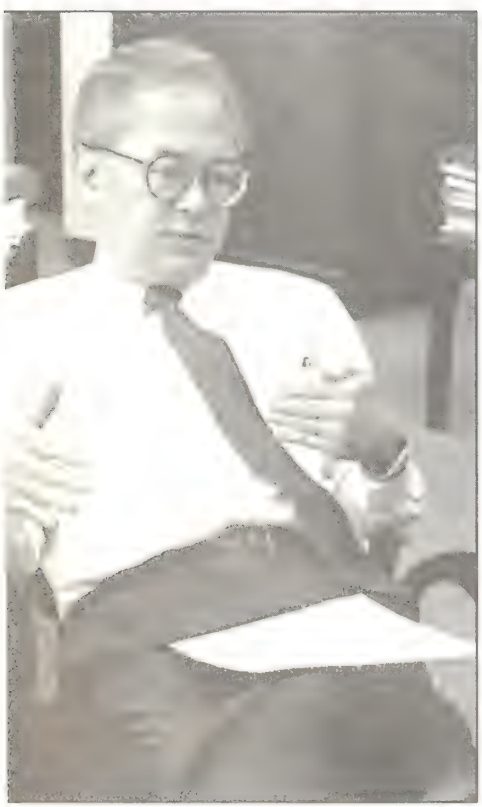
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'Shake-up' in drug

Bob Carlson
Indianapolis



Like physicians, hospitals and insurance companies, the $65-billion-a-year U.S. pharmaceutical industry has come in for its share of scrutiny from the presidential task force on health care. Specifically, American drug companies have been called to account for raising the nation's health care bill by raising drug prices. In an effort to control rising health care costs, the task force may include controls on drug prices in its recommendations.

Such controls would be wrong, says August Watanabe, M.D., group vice president at Lilly Research Laboratories, Eli Lilly and Co., in Indianapolis. Putting a cap on drug prices would put a cap on profits, which in turn would limit investment in research and development. The net result, according to Dr. Watanabe, would be a deterioration in the overall quality of medicine.

In this interview with INDIANA MEDICINE, Dr. Watanabe points out that profitability in the pharmaceutical industry is already being eroded by sharply rising costs, not just in the United States but world-wide. He sees the costs of developing and launching a new drug rising substantially beyond the current estimate of $350 million by the end of the century and forecasts an industry "shake-out," with far fewer players remaining in the game. On a brighter note, he also talks about Lilly's new drugs – more than at any time in the company's history – now in the late stages of research and development.

Dr. Watanabe came to Lilly in 1990 from the Indiana University School of Medicine, where he was chairman of the Department of Medicine and director of the Regenstrief Institute for Health Care. He is responsible for pharmaceutical discovery research at Lilly. He also continues to hold academic appointments as professor of medicine and pharmacology and toxicology and as a member of the graduate school faculty at the IU School of Medicine.

He previously served as a consultant to Bristol-Myers Co., Farmitalia Carlo Erba and Merrill-Dow Research Institute and as chief of cardiology at the VA Medical Center at IU.

Dr. Watanabe has given numerous presentations internationally, has authored or co-authored more than 100 publications and has been a member of many national committees, including those of the American College of Cardiology, American Federation for Clinical Research, American Heart Association, American Society for Pharmacology and Experimental Therapeutics, the U.S. Food and Drug Administration and National Institutes of Health. He is a fellow of the American College of Cardiology and the American College of Physicians. Dr. Watanabe is a 1967 graduate of the IU School of Medicine.

INDIANA MEDICINE: **How have the quality, effectiveness, safety and variety of drugs changed in recent decades?**

Watanabe: They've changed in several ways. Perhaps most importantly, a lot of the drugs that we now use, both the acute drugs, which are given for short periods of time, as well as the chronic drugs, which have to be given for days or months or sometimes indefinitely, are very safe. Like

industry predicted

antihypertensives. One of the reasons there's been such an advance in treating hypertension is that a lot of the current drugs are very safe. In fact, a lot of them don't have any side effects at all. In the past, there were some drugs that were efficacious, but they had a lot of side effects or safety issues. One of the reasons that Prozac, one of the Lilly drugs, is such an important advance in treating depression is that it's much freer of side effects, much safer than some of the earlier generation antidepressant drugs. So safety has clearly improved.

Effectiveness. In many categories, lipid-lowering agents, antihypertensives, antidepressants, drugs for osteoporosis, we now have agents that are much more effective. In the past, we may have had some agents that would produce a desired therapeutic effect, let's say lowering of blood pressure, but they weren't very powerful. And so a significant percentage of the patient population wouldn't respond to the drugs that were available. Now we can treat 80% to 90% of the patients with hypertension,



and, therefore, the bad consequences of hypertension are much less common. Safety and quality are interlinked. If you have a drug that's safer, then of course the quality's better.

I think another aspect is convenience. In the older days, 15, 20 years ago, for example, there were a number of drugs that were relatively effective, fairly safe, but the patient had to take them four times a day. Now, if a patient has to take a drug four times a day, can you imagine how difficult that is for the patient to remember? At work, or play, or shopping or whatever, it's very difficult to be compliant. Therefore, even though

> *"Probably within the next year there will be a gene discovered that's responsible for breast cancer."*

the drug is available, the patient's not getting the benefit of it. A lot of the medications now are once a day or patches that can be placed on the skin that can stay there maybe several days, maybe a week, maybe even longer. Some others are actually implanted under the skin. There are much more convenient ways of taking drugs, and that's another feature that adds to the quality.

A lot of the modern drugs are very potent, much more potent than the older drugs. Much less is required to produce the desired therapeutic response. This is another example of improved quality because that means there's less of the chemical that the patient has to take in order to get the desired effect.

In some of the more common diseases such as hypertension and hypercholesterolemia, the physician now has half a dozen to a dozen different drugs to choose from. By having a whole portfolio of treatment, they can almost customize the therapy for a given patient, depending on the individual needs of the patient. If the patient develops side effects with one kind of drug, they can then switch to another. Because of the greater variety [of drugs] in many diseases, we can treat almost every patient.

INDIANA MEDICINE: **Biotechnology has captured the interest of the public and the medical profession. How do you see the impact of biotechnology in terms of new developments and new therapies?**

Watanabe: Biotechnology is helping us understand pathophysiology of diseases much better. Recently there was the announcement of a newly discovered gene responsible for colon cancer, for example. Probably within the next year there will be a gene discovered that's responsible for breast cancer. The gene involved in certain types of Huntington's disease has been identified. So the biotechnology approach to research helps in actually understanding disease pathology. Based on that, novel approaches to therapy can be developed, and targets for disease can be more elegantly identified, and then drugs directed against those tar-

gets can be searched for.

Also tied to that are more elegant diagnostic tests. If we know, for example, the genetic basis for a certain kind of disease, then eventually, gene-based diagnostic tests can be developed so people can be screened for the presence of certain abnormal genes, mutated genes, and then it's possible to predict whether that individual will develop the disease.

In addition to all that, biotechnology has been used to study various key proteins that are involved in the normal function of the body. Biotechnology allows us to characterize those protein structures much more rapidly and much more precisely and then this allows us to begin to search for chemical compounds that could eventually become drugs that would interact with these protein structures – enzymes, receptors and channels. So biotechnology helps in the search for new possible drugs.

Finally, biotechnology is used in production of drugs. Humulin, recombinant human insulin, which is a Lilly product, is actually produced by biotechnological engineering of cells that have been genetically modified so they make insulin. There are a number of other hormones, such as human growth hormone and erythropoietin that are made by recombinant technology. Between a half dozen and a dozen drugs now on the market are produced by biotechnological approaches.



Monoclonal antibodies are another area of importance, both in diagnostics and therapeutics. Many of the monoclonal antibodies that are being used now are modified to be much more precise in their targeting of the antigen and also much closer to human types of proteins, as opposed to animal types of proteins like murine proteins. And this engineering of antibodies is accomplished by biotechnological approaches.

INDIANA MEDICINE: **Could you describe a typical development cycle and cost estimate for a new drug?**

Watanabe: The discovery phase can range anywhere from a few years up to maybe a decade, depending on how new the area of research is, how cutting edge, and on the complexity of the problem. During that period of time, sometimes as many as 10,000 or more compounds might be synthesized to look for certain kinds of activity against the disease state before a single compound moves forward into the developmental phase.

When a compound finally moves into development, that phase can take anywhere from six to seven years on the low end, if everything works well, or more commonly, if things don't move quite as fast, it can be significantly longer than that, up to 12 or 14 years. The total duration then could be anywhere from 10 to about 20 years. The range of discovery/development time for most drugs is anywhere from 10 to 14 years.

The total cost of all this varies from drug to drug. The amount that most groups now agree is fairly accurate for discovery and development is about $350 million – about a third of a billion dollars per new chemical entity that eventually becomes a drug and is put on the marketplace.

INDIANA MEDICINE: **How do you respond to increasing concern among patients and physicians about the cost of prescription drugs?**

Watanabe: We're all concerned about rapidly rising health care costs and the increasing percentage of our national expenditures that goes into providing health care. But we also need to remember that prescription drugs account for a very small percentage of the total health care budget, anywhere from 5% to 7% or so, depending on the specific patient population you want to discuss – clearly less than 10%, a relatively small part of the overall pie that we call health care costs.

If one discusses specific pharmaceutical agents such as some of the modern antidepressants, the modern lipid-lowering agents, the modern antihypertensive drugs, very important chronic medications, the cost per day for the patient is relatively small compared to other kinds of therapy that might be required or other kinds of economic consequences if

the patient didn't take those drugs. For example, a lipid-lowering agent or an antihypertensive may cost anywhere from, let's say $1 to $3 a day, which isn't really that terribly expensive. In fact that's less than a pack of cigarettes.

A pack-a-day smoker is spending over $2 a day smoking cigarettes, and some of the same individuals will complain about having to spend $2 a day for a drug that will control their blood pressure. So, relatively speaking, it's not that high. But even more important, by controlling the blood pressure, the patient is preventing the development of atherosclerosis, which might lead to heart attacks, or angina, which then might require coronary bypass surgery or angioplasty, which are very expensive and lead to significant disability.

Antihypertensives are also given to prevent stroke, another terrible disease, [with] terrible morbidity [and] terrible disability that usually results. And if one calculated the cost of a stroke to society, it's extremely expensive. In many cases you're removing a productive citizen from the work force, or you're disabling a mother or father who can't take care of their family as well any more, etc. So, if you view it that way, [the drug] really isn't that expensive.

We discussed earlier how long it takes to develop a drug, anywhere from 10 to 20 years total, the average being seven to 14 years. We also discussed the fact that it costs about $350 million, on average, to discover and develop a drug. The pharmaceutical companies that make these investments have to get a return on that investment. Otherwise, they wouldn't survive and therefore would not be able to continue to do all this research and development. But there's a limited time during which they can get that return on investment. The patent laws in the United States allow patent exclusivity for 17 years. If a patent is filed and processed and maybe even issued during the late discovery phase of a compound, the development time could consume seven to 10 years of that patent life. When the drug is finally launched, in some cases there are only five to seven years left of patent exclusivity. If the company is unable to recover a significant part of its investment during that remaining time, it's never going to recover its investment because the generic competition kicks in as soon as the patent runs out. So there's a time window during which the company has to recover all of its investments for that particular product. That's another factor that determines pricing.

> ***"There is a whole variety of factors that determine pricing, but I still maintain that the prices are fairly reasonable."***

Let me add one more. For a pharmaceutical company to be successful and discover medications that are going to be available for physicians to treat patients with, they have to invest a large percentage of their profits into R&D. In fact, the average amount invested by the large multinational pharmaceutical companies ranges between 12% and 17%. This large percentage of investment in R&D is relatively unique to the pharmaceutical industry. Most other large industries don't invest at that level. In order to invest that large an amount into R&D, there has to be an adequate amount of profit during that window of opportunity, while the patent still exists.

There is a whole variety of factors that determine pricing, but I still maintain that the prices are fairly reasonable. If we were able to come up with a drug for Alzheimer's disease that costs anywhere from $2 to $5 a day to prevent the progression of Alzheimer's disease, I think that'd be a pretty good bargain, don't you? Or if we could come up with a drug that would stop the progression of AIDS and maybe even eliminate the virus, but the patient would have to take the pill daily for the rest of their lives and if it costs several dollars a day, maybe even $7, $8 or $10 a day, I don't think most patients would complain too much.

INDIANA MEDICINE: **One example one runs across is that drugs that cost $10 in 1983 cost $23 today. Can you comment on that apparent disparity in the rise of drug prices relative to other price rises like the Consumer Price Index or inflation?**

Watanabe: If you select an individual drug and follow it over time, it's true, perhaps in some cases, the rate of increase in price

is greater then the rate of increase in the CPI or inflation. But if you look at all of the pharmaceutical products that are available from a company, if you look at all the prices of those compounds in the aggregate, the rate of increase in price is not excessive and does not exceed the rate of inflation. In many cases, I think it's actually less than the inflation rate. In Lilly's case, the price increase since the early 1970s of all our drugs in the aggregate is less than the rate of inflation. What you hear politicians stating are certain specific examples taken out of context to make their point.

INDIANA MEDICINE: **At some point in Phase I or II or perhaps even III, does it happen that a company just looks at the remaining exclusivity on a product or a potential product and says maybe we ought to get out?**

Watanabe: I'm sure there are occasions in which a company may be in Phase II or sometimes even in Phase III on a new drug and something happens. Like maybe a competitor reveals that they also have a drug, which actually looks a little bit better, but is in the same phase of development, or maybe even a little bit ahead. The company may actually decide, even though it has already spent $200 million, to stop this one because it's not going to be very successful commercially. Yes, that can sometimes happen.

But the other thing that sometimes happens is early in Phase III, after development has been going on for a number of years and tens of millions of dollars have been spent, an important toxicity may be found. Development of the drug would have to be terminated. In other words, there are lots of failures, even late in development. This is a very risky business. Even when a drug is launched, for the first year or two you're not sure that there's not some pit waiting out there for you to fall into that will eventually force you to stop the drug. These are some of the factors that lead to the high cost.

INDIANA MEDICINE: **Some of the miracle drugs on the market can literally make the difference between life and death, and people are willing to pay the price no matter how expensive. How do drug companies, which in that case could charge just about anything they wanted, determine their price?**

Watanabe: First of all I think there's the desire for reasonableness. What will the market bear? How will the patients respond? How will the physicians and the payers, who are the decision-makers as far as which drugs to use, how would they respond? The cost of producing the product is considered. In some cases, biotechnology products, for example, are more expensive to produce than certain kinds of relatively more simple chemical compounds.

Competition [is also considered.] If a drug is the first one out there and therefore it's a major breakthrough, that usually means a lot more was invested to get it there. It also means that there's less competitive pressure, at least for a while. And that also influences pricing to some degree. And then of course, as I mentioned earlier, the company has to get its return back on the investment, in a limited time frame, during that window of opportunity while the patent still is in force. They not only need to get the return back but they have to have some profit in order to be able to invest in R&D and try to discover drugs for the future.

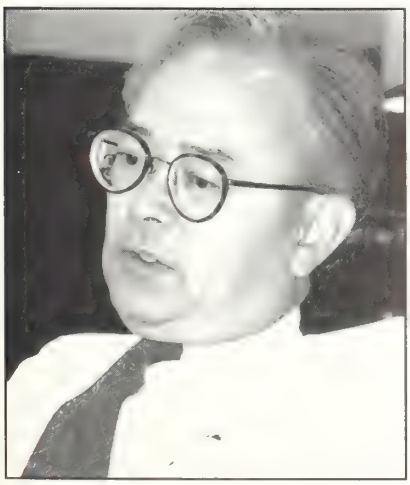
The patient is also considered by the company. In other words, we try to be as reasonable as possible and provide the drug at the most reasonable possible price. By the way, I would say most large pharmaceutical companies have programs in which they will provide drugs free of charge for a patient who needs it but just absolutely can't afford it [because he] doesn't have any insurance, can't get Medicare or Medicaid, or for whatever reason cannot in any way pay for it. The company will provide it, free of charge. And this is true for Lilly as well as our other brethren multinational companies.

INDIANA MEDICINE: **It has been said that Indiana physicians are extremely loyal to brand name pharmaceuticals and don't generally prescribe generic drugs. Because this increases health care costs, would it be appropriate to require physicians to prescribe generic drugs for Medicaid patients?**

Watanabe: I don't think just Indiana physicians but physicians in general want to be very assured and confident that whatever they're prescribing has the safety and efficacy qualities that they're confident of in a brand name drug. When physicians prescribe a drug made by Pfizer or Merck or Lilly, they know the research

that went into it and they know the quality controls that go into the development and manufacturing of that particular drug. They're confident of it, and that's why they specify those proprietary types of drugs. If they were confident of generic versions of those same drugs, then I'm sure there would be no problem prescribing them.

But, generic companies have been spotty. Some of them have been fine, but others have been unable to produce top quality products and some of them have been outright fraudulent. They've submitted fraudulent information to the FDA in order to get their drugs registered. There was a major scandal on this several years ago. That damages the reputation of those generic companies, and I think that's one of the reasons that some physicians, not only Indiana physicians, have been hesitant to prescribe certain kinds of generic drugs. If it can be verified, proven, over time, that certain generic drugs are just as good as a brand name drug, then there's no reason why they shouldn't be used in any kind of a patient, whether that be Medicaid, Medicare or private insurance reimbursement types of patients.



The key here is quality. What we have to ask ourselves is, if I had to take a drug, and if it were available as a major brand name or a generic, would I be willing to take the generic just as confidently as I would take the major brand name? If the answer to that is yes, then I should be able to prescribe it for my patients. If the answer is no, I'd have some doubts for myself or for my family member, then I'm probably not going to prescribe it for my patient either.

INDIANA MEDICINE: **How much do pharmaceutical advertising and promotion affect the cost of drugs? I think the rule of thumb is something like 20% of sales. Is that about right?**

Watanabe: I would guess it to be between half and about the same as the R&D costs, anywhere from 7% to 15%.

Let me discuss something else in this line. If one analyzes all of the important pharmaceutical agents that are currently used or that have been launched in the last 10 to 20 years, greater than 95% of them were discovered and developed by pharmaceutical companies. This is something that most people don't realize. A lot of people think lots of drugs came out of universities or the National Institutes of Health. That's not true.

Point number two, the vast majority of pharmaceutical companies, again, greater than 95%, are located in capitalistic countries. They are therefore successful capitalistic businesses. Two major reasons that pharmaceutical companies in the United States and Western Europe and now, to a lesser degree Japan, are so strong are because science is so strong in those countries and because those are capitalistic countries. The combination of research and the desire to improve humanity by making advances in medicine, combined with the profit motive, is very powerful. That's why breakthrough drugs have been discovered and developed. If the profit incentive were removed and everything else was maintained, drug discovery and advances in medicine would begin to fall off very rapidly and dramatically.

That's one of the real worrisome things about what's happening right now around the world but also here in the United States. Some of the extreme views and positions taken by politicians against certain aspects of medicine, including the pharmaceutical industry, and their extreme rhetoric, attacking the industry as price-gouging and so forth, if some of their objectives are implemented – I think it's very worrisome for all of us. I think medical progress is going to be dampened if our governments remove the profit incentive, which is very important in all of this. There has to be some profit, because that's part of the motivation that drives this machine. Also, money is reinvested back into R&D, which keeps the whole thing going, keeps new drugs coming forward. Advertising and marketing are ways of gaining some profit and maintaining one's position vis-à-vis the competitors. So we've got to have some of that.

Now, obviously, profit's got to be within reason, and that's what we're all discussing and negotiating about. I believe that it is quite reasonable, and it's fair to continue to discuss that in an open forum as we're now doing here in the United States. But we need to be sure that we don't take it too far and completely remove profitability from the pharmaceutical industry. Because if we do that, the quality of health care is going to begin to deteriorate.

INDIANA MEDICINE: **At the annual Lilly stockholders meeting there was a report regarding new drugs in the pipeline at Lilly. What can you tell us about the potential new products from Lilly?**

Watanabe: Between now and 1994, we're going to have close to 10 compounds in Phase III, and that's unique for us as well as relatively unusual for the industry.

We have a drug that is very promising for osteoporosis called Raloxifene.

We have another compound, Fialuridine (FIAU), that looks very promising for hepatitis B, which is a form of viral hepatitis in which a certain percentage of patients develop a chronic state. If that's not eradicated, those patients are at risk of developing cirrhosis of the liver, sometimes liver failure. Sometimes these patients need liver transplantation. Some of these patients develop liver cancer. This is a serious disease.

We have another compound that looks very promising for schizophrenia called Olanzapine. Schizophrenia is perhaps the most common of the serious psychoses that require patients to be hospitalized in psychiatric hospitals. If they're not hospitalized, patients with this problem are often dysfunctional, so they can't go to school, they can't maintain employment, can't be productive citizens. Right now, most of the treatments for this disease are either not very effective, or they cause very serious side effects, including some neurological side effects.

[Another new compound is] a new form of insulin, Humalog, a form of insulin that has a rapid onset and offset of action whenever it's injected into a patient. In other words, it behaves much like the pancreas behaves whenever you eat a meal. You get a quick increase in the insulin concentration circulating around the blood, and then it rapidly decreases after you've metabolized the food. This form of insulin, because of its rapid onset and offset of action, allows a diabetic to inject himself at the beginning of a meal. The current insulins that are available are slower in their onset and offset and, therefore, have to be injected by the patient anywhere from 45 to 60 minutes before the meal. This is inconvenient and sometimes can lead to hypoglycemia.

"But we need to be sure that we don't take it too far and completely remove profitability from the pharmaceutical industry. Because if we do that, the quality of health care is going to begin to deteriorate."

And then there's a drug called Gemzar, a new anti-tumor agent that has very good activity against a number of solid tumors found in the breast, colon, pancreas and lungs. Currently we're developing Gemzar for registration for a certain type of lung cancer called non-small cell lung cancer as well as for pancreatic cancer. This drug also looks very promising. We hope to submit the registration package within the next year or so.

INDIANA MEDICINE: **Would you speculate on what the future holds for the major pharmaceutical companies in the United States, including the impact of health care reform on drug development?**

Watanabe: Right now I think there are two major forces occurring around the world that will eventually affect pharmaceutical companies as well as drug development. Number one, rapid and sustained increases in costs for R&D. We talked about the $350 million [it takes to discover, develop and launch a drug]. By the end of the century it'll be substantially more. I don't know how much more, but it'll be substantially more. Cost of drug development is rising dramatically. At the same time, there is greater and greater downward pressure on profitability. All of the discussions and the probable legislation that will come out on health care cost containment, all of the politi-

cal forces that are opposing profitability in the pharmaceutical business, are putting a lot more pressure on the ability of pharmaceutical companies to generate profit that they can use to invest into R&D. These two forces are sort of working against each other and that is going to impact the major pharmaceutical companies, not only in the United States but around the world.

What it's going to lead to is probably some increased consolidation. In other words, companies will be forced to combine forces and go into alliances in order to survive. There will probably be fewer really successful major pharmaceutical companies in the next century. There will likely be many fewer small biotechnology companies. Most of them will not exist in another decade or so. They will either be swallowed up by larger companies, or they will combine with several other smaller companies to try to develop critical mass in order to survive. A number of them will go bankrupt.

I think there's going to be a shake-up in the industry. The strong companies will get stronger, maybe even will align with other strong companies to get even better. The average-to-weak companies will either go into alliances with other companies or cease to exist. If the political pressures and the cost control pressures get too severe, ultimately I think that will begin to have a negative impact on R&D, and only a few of the really successful companies will be able to afford to invest in R&D. Less of it will be happening, and therefore the overall quality of medicine will begin to deteriorate. ❑

This interview was conducted by Bob Carlson, a health care communications consultant in Indianapolis.



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Managed care and managed competition:

Preparing for an uncertain future

Glenn T. Troyer
David E. Jose
Indianapolis

The old adage "if it ain't broke, don't fix it" has been used to respond to various reform proposals in support of maintaining the status quo. In the context of the current health care crisis, however, many providers and consumers (and most politicians) agree that certain aspects of the present health care delivery system are indeed broke and need to be fixed. The Indiana Commission on State Health Policy identified the following 10 items as root causes or problems leading to the health care cost escalation crisis:

1. Lack of effectiveness and outcome measures of the delivery of health care services;
2. Inappropriate reimbursement and economic incentives to providers and consumers;
3. The proliferation of technology;
4. Excessive and ineffective regulation affecting health care providers;
5. The delivery of unnecessary health care services;
6. Economic and demographic changes in the health insurance markets;
7. Lack of agreement on goals or objectives of the health care delivery system among consumers and providers;
8. Societal attitudes toward risk and liability;
9. Underlying conditions in society at large, which in turn make demands on the health care delivery system; and
10. Dramatic demographic increases in the aged portion of the population over the next five decades.[1]

Last year in the 102nd Congress, the Managed Competition Act of 1992 (H.R. 5936) was drafted and introduced by the Conservative Democratic Forum in an effort to address the current health care crisis. Whether or not the concepts of managed care and managed competition, as envisioned in H.R. 5936, will address the root causes or drivers of the health care crisis will be the focus of much discussion and political maneuvering at both the federal and state levels during the next few years. Even though it is not known if H.R. 5936 will become law, many political analysts believe that concepts contained in the Managed Competition Act of 1992 will be integral to President Clinton's health care reform package. It is nearly impossible to accurately predict what our health care delivery and payment systems will be like two or more years from now. It is, however, valuable to analyze the issues contained within some of the policy concepts that are being discussed in order to prepare for the uncertainty of the future.

Managed care

The term "managed care" commonly refers to those sets of rules that are used by third-party payers to affect access and payment for the services provided. These arrangements are characterized by prior, concurrent or retrospective review; patient financial incentives or disincentives concerning use of and access to physicians, hospitals or free-standing facilities; the use of a closed panel of primary care or "gatekeeper" physicians; a limitation of benefits and types of treatments available for high cost patient care services; and a myriad of important contractual provisions in physicians' contracts. While HMOs were the major initial effort of managed care, the 1980s saw the development of various preferred provider organization models incorporating characteristics of HMOs and traditional fee-for-service practices.

Managed competition

In contrast to managed care, managed competition focuses on the insurance or financing aspects of patient care for each patient. The Managed Competition Act of 1992 (MCA/92) would establish a National Health Board (NHB), which would create a set of health benefits and targets aimed at bringing health expenditures into line with overall economic growth of the country's economy. The NHB would be comprised of consumers, physicians, health care providers, government, business and others, and be appointed by the president. Standardized claims forms and claims processing also would be established.[2]

The next level below the NHB would be the Accountable Health Plan (AHP), whose role would be to offer standard health benefits, comply with insurance reforms and disclose information on medical outcomes, cost effectiveness

and consumer satisfaction. The premise is that AHPs would afford consumers the opportunity to make informed choices about their health care, often prodded by co-payments and deductibles. The unique role of the AHPs would be to offer high-quality, low-cost health care by offering insurance and health care delivery as a single product, utilizing various existing insurance forms including indemnity, PPOs and HMOs.[3]

Below this level of structure would be the Health Plan Purchasing Cooperative (HPPC), an organization functioning as a broker on behalf of individuals and small businesses to purchase the appropriate products from the available AHPs. Large businesses, however, would be able to buy the insurance products directly from the AHP.[4]

Will the MCA/92 address current problems?

Insurance underwriting and escalating premiums have received significant attention in the media. In an effort to address these issues, the AHPs could not base rates on individuals' medical history or pre-existing conditions. Only geography, and to a lesser extent, age, could be variables affecting rates. As a result, the AHP focus would be on early intervention, screening and immunization.[5]

Universal access, the rallying point for many consumer groups, is addressed by the MCA/92. Individuals and small businesses would work through the HPPCs to provide universal access. All people below the current poverty threshold would receive health insurance paid by a new government program. Those individuals and families falling between 100% and 200% of the poverty threshold would receive some type of federal subsidy to purchase a health plan. States would no longer be required to finance Medicaid programs, but they would gradually assume the expenses for long-term care for the poor. Rural and underserved areas would experience increased funding for community health centers, migrant health centers and the National Health Service Corps.

Tax incentives or disincentives for health insurance have been perceived as contributing to a system that insulates costs from health care decision making.

Tax incentives or disincentives for health insurance have been perceived as contributing to a system that insulates costs from health care decision making. Under the MCA/92, 100% of a basic health plan's costs would be tax deductible for all businesses and individuals, including self-employed. Any health insurance coverage above the basic plan, however, would not be tax deductible. Proponents argue that managed competition is designed to be tax revenue or budget neutral. The sources of revenue (or cutback in expenditures) that would permit this budget neutrality include eliminating the limit on income subject to Medicare tax, limiting the deductibility of health insurance expenses and redirecting Medicaid spending.[7]

MCA/92 also attempts to acknowledge the need for tort reform as a component of the total health care cost issue. It seeks to reduce litigation and defensive medicine behavior and associated costs by eliminating certain non-economic damages in lawsuits and by reducing the oftentimes long statute of limitations. This would be accomplished by the creation of federal law dealing with tort reforms in a way that would supersede state laws unless the state statutes were more stringent.[8]

Business and legal considerations

While it is difficult to envision how such a managed competition system will be implemented, it is certain to affect the way physicians practice. This system will require more physicians to contract with AHPs, multiple hospital systems or other integrated delivery providers to offer cost effective and coordinated health care services. Experience with current managed care plans has raised legal concerns with which physicians should become familiar. While the legal issues often become significant points in contract negotiations between a physician and a managed care provider, a physician should address preliminary business issues before entering into a managed care arrangement. These include:

1. What are the business goals

and objectives of your practice?

2. How does the proposed managed care contract fit your business goals and objectives in terms of:
   a. market share;
   b. profit from the use or non-use of professional services;
   c. profit from the use or non-use of non-professional services;
   d. profit from the hospital risk pool, if applicable; and
   e. experience in this line of business?
3. Do you have the proper business organization, structure and relationships to deliver the requisite care, or will you need to contract for the delivery of certain services?
4. Will you need to add any facilities or services (e.g., lab, x-ray, computed tomography, magnetic resonance imaging, waiting rooms and seating, personnel, examination or outpatient surgery rooms, computers)?
5. Are you willing to deliver the type of care being required or demanded by the managed care entity?
6. Does your practice generate the necessary cash flow to absorb unusual incurred or accrued expenses faced in a managed care arrangement?
7. Do your financial statements accurately reflect your practice?
8. How experienced are you in understanding the financial risks and loss exposures that can occur in the managed care arrangement?
9. Are you willing to make internal financial and accounting changes in order to accommodate the requirements of the managed care business?
10. Do you have the computer resources to collect and analyze the prospective income and expense elements in a managed care practice?
11. Do you understand the market and market trends for the development of your practice, such as:
    a. relationship with major area employers;
    b. relationship with own patients;
    c. geographical location;
    d. current and potential competitors; and
    e. reputation in the community?

Once a physician has analyzed the business issues surrounding the prospects for his or her practice in this evolving managed care/competition system and decides to enter into contracts with managed care plans, AHPs or other entities, the physician will have to evaluate the contract terms being proposed. Most contracts may appear to be all-encompassing and non-negotiable, but there are some standard provisions that should be reviewed. An initial consideration should be the length of the contract and the ability of either party to terminate it. This will entail determining those circumstances in which either party may terminate "without cause," and what circumstances may serve as "cause" for termination. The length will have more significance if the agreement is exclusive or restrictive to the physician in other ways.

Many managed care contracts contain an extensive list of definitions, which are extremely important because they define the terms that are used throughout the contract. Physicians and other providers often assume that a term is used in its common or ordinary sense. That can be a dangerous assumption, however, if the definition section of the contract was more restrictive or expansive in the definition intended for the term in the contract.

Indemnification and hold harmless clauses continually raise problems for both parties concerning the scope and circumstances in which each party agrees to indemnify the other. Sometimes pre-negotiation of these provisions will be one-sided. While reciprocal arrangements often may be the best and fairest resolution, they can lead to problems as well. These provisions are essentially contractual transfers of risk from one party to the other. As a result, the parties may need to secure contractual liability insurance coverage under their general liability insurance policies to financially support these contractual obligations. However, if this is not considered or if the physician is unable to secure such insurance coverage, he may be placing his entire medical practice at risk by agreeing to sign such an agreement.

Medical records will become a very thorny legal conundrum as they become more computerized and as access is sought by more reviewers for purposes of utilization and outcome analysis as well as payment. In addition, consideration should be given to the data that may be used in quality assessment or litigation review, how data are collected and whether the managed care/competition entity is acting in accordance with the Indiana Peer Review Statute. Contract terms that

give adequate consideration to these issues and comply with confidentiality laws also must address changing technology to be beneficial.

Physicians in Indiana benefit from the protections under the Indiana Medical Malpractice Act, also called the Indiana Compensation Act for Patients (INCAP). It is important to understand whether the managed care/competition entity is "a qualified health care provider" under INCAP and whether or not the insurance provision includes that requirement. If one of the parties is not included under INCAP, the other party may be drawn into litigation in state court as opposed to the professional confines of the review procedures under INCAP.

Insolvency of a managed care entity can be the source of serious financial and operational distress for a contracting physician. Insolvency provisions frequently will require the physician to continue to provide patient care to members of the plan even though the physician has not been paid for past services. Bankruptcy proceedings also can impose limitations on a physician's ability to terminate a contract even though the physician may believe that termination is permitted and justified under the contract language. These provisions need careful analysis. It will be interesting to see how these provisions operate in the managed competition arena where there should be more coordinated efforts toward universal access to care.

Physicians should be careful not to unintentionally agree to exclusively provide services for one particular managed care/competition entity. Although such agreements have historically been rare, in the last few years more managed care entities have been asking for exclusive arrangements. This may be motivated by a desire to market a particular panel of physicians to employers with whom the physician may already have a favorable reimbursement arrangement, either directly or through a third-party payer.

Covenants not to compete, or restrictive covenants, also have been included in managed care contracts more frequently in recent years to protect the managed care entity's business. In Indiana, a properly drawn restrictive covenant is usually enforceable. For the physician, however, this is a very serious business decision and should not be taken lightly. The era of managed competition will not completely change the traditional personal relationship between physician and provider, and most political analysts are saying that some level of physician choice will be retained in any federal initiative. Thus, this will continue to be an important contract clause requiring careful attention and negotiation.

While there are a variety of other legal provisions and issues that the physician must evaluate before entering into a managed care contract, the above list focuses on several of the more significant issues that have posed problems for large numbers of physicians in various practice settings.

In conclusion, two trends appear to be emerging: managed care contracting will develop further and perhaps evolve into some type of federal initiative, like the MCA/92, and physician contracting with managed care entities will become even more significant to the practicing physician. Consequently, physicians are well advised to prepare for this new environment by developing a better understanding of the types of managed care contracts and their problematic provisions and to manage their practices within the constraints of those contracts and provisions. ❑

Glenn T. Troyer and David E. Jose are partners in the Indianapolis law firm of Locke Reynolds Boyd & Weisell and represent physicians and other health care providers as part of the firm's health law practice group. Troyer also was the chairman of the Problem Definition Technical Advisory Committee of the Indiana Commission on State Health Policy.

The material in this article is provided for general information only and should not be understood as legal advice concerning any particular situation.

References

1. *Hoosier Health Reform: A Strategic Plan for Indiana's Future*, p. 78, final report, Indiana Commission on State Health Policy, November 1992.

2. Loos GM, Dutton TE: Healthcare reform models and implications. *Healthcare Financial Management*, March 1993, p 24 (Healthcare Financial Management Association, Westchester, Ill).

3. Id p 24.

4. Id p 25.

5. Id

6. Id p 27.

7. Richardson M: Managed competition comes to the fore in health care reform debate. *Tex Med*, 89:58-61, 1993.

8. Id

Hospitals buying physicians' practices

Morris D. Wildey
Indianapolis

James Black, M.D., has been a physician for 34 years. In the later 1980s, he ran across some business needs that caused him to make a major decision – he sold his suburban Indianapolis group practice in Brownsburg in 1988 to Methodist Hospital.

Many Indiana physicians today are making similar arrangements with hospitals. As they find themselves spending more time on ways to handle escalating costs and burdensome government regulations than on patient care, hospitals are ready to come to their rescue.

Hospitals and clinics in Indiana have recognized the financial and government forces that are closing in on private physicians. The institutions have set up management companies or operations that take care of the business-related aspects of a practice. Those services range from helping relieve doctors of the pains associated with patient billings, to hiring and training office staff, to finding furniture for the office.

For instance, in the Indianapolis area, St. Vincent Hospital has a new program that offers business services to doctors. Community Hospitals will set up new doctors in offices complete with staff to handle paperwork. Methodist Hospital and St. Francis Hospital Center also offer similar operations. The trend is growing in other parts of the state as well – Arnett Clinic in Lafayette and St. Mary's Medical Center in Evansville are examples.

Certainly the buying/selling trend is not a novelty anymore. Versions of it have been going on for five or more years. The trend seems to have shifted to a higher gear recently, though. Higher operating costs, increased government regulations and paperwork, and other factors are pushing the reality of large networks of providers that include hospitals, family doctors, specialists, laboratories and business services into the mainstream of Indiana medicine.

Although doctors have different reasons for considering selling a practice or turning over the business aspects to a management service and hospitals have a variety of programs for doctors who choose to join a network, there are similarities on both sides.

For doctors, besides determining the best answer to the business bottom-line equation, many simply are searching for ways to devote more time to seeing patients and less of it filling out papers for the government.

For hospitals, they are building relationships with doctors and diversifying their services, which makes them stronger institutions.

Once the doctors join the networks, though, are all their business-related problems solved? Are there ethical concerns to be considered on both sides once primary care physicians give up their independence and begin getting a paycheck from a hospital?

The public press in Indiana has started examining the issue. Questions being asked include:

- Will the new networks cause higher health costs because they create less competition?
- Are hospitals buying primary care practices as a hedge on coming health care reforms to protect their market share of patients and revenue?
- Who does the physician end up being responsible to, the hospital or the patient?

Marc Rodwin, author of *Medicine, Money, and Morals - Physicians' Conflicts of Interest* and an associate professor of law and public policy at Indiana University, also has raised questions.

If nothing else, he said, in many instances "the appearance of conflict of interest is certainly there. What if the doctor is employed by a hospital but holds himself out as an independent? The patient is unaware."

Yes, the trend is controversial to some. Because it is and because it's growing, INDIANA MEDICINE asked people who have been involved in the process why they made the decisions they did.

"We needed a new office, and we couldn't decide how to handle it or finance it," Dr. Black said about the main reason that caused him to begin looking at several options and eventually led him to hook up with someone else.

Today he believes his decision was a good one. In the beginning, though, he wasn't sure. His practice was the first bought by Methodist when the principal stayed with the business. Dr. Black is the practice manager. There were a lot of rough edges in the working arrangements because of that.

Over time they smoothed out. Dr. Black said the relationship

improved when Methodist set up a subsidiary, Practice Management Inc., and the last two or three years he has felt comfortable about having sold his practice.

Now the practice benefits from help with medical records, accounting, advertising, cost containment, obtaining financing for acquiring new equipment, training and maintenance of the physical plant.

However, he added that doesn't mean he doesn't have business issues remaining to address himself. Plus, the arrangement with Methodist doesn't automatically make more time available for the practice's doctors to see more patients because someone else is doing paperwork.

The arrangement is not a magic cure to business-related issues.

"It's too simplistic to say selling your practice frees you up to see just patients," Dr. Black said. "It's mostly a business decision. I don't mean you make more money. It's nice to have someone with deeper pockets than you have."

Dr. Black has four partners, and there is discussion about hiring another doctor. The practice has grown every year since it was purchased, but he admits some of the growth probably would have occurred without the arrangement with Methodist Hospital.

As for any ethical concerns, especially in the area of patient referrals, Dr. Black sees no problem. There are legal prohibitions against what some call "buying patients," he said. Besides, his arrangement with Methodist has never come close to the issue.

"I believe it is unwritten in any case that when someone pays the bills you should support them," he said. "(But) I've never felt that pressure."

For those who may be thinking about selling their practices, Dr. Black has some advice.

"Spend a long time talking," he said. "Make sure that getting along is part of the decision."

Gordon Welk, M.D., had a solo practice in Rossville, a community of about 1,500 people, for 18 years. He sold it in 1992 to the Arnett Clinic in Lafayette. Selling his practice was something he had considered doing for the last four or five years as he saw his profits decrease and his expenses increase.

He didn't have any purchasing power when it came time to buy supplies. When he needed immunizations, he didn't need a big order so his unit costs were high. Then came what he described as the "final blow" – the CLIA regulations.

The regulations brought more certificates to be completed and more inspections to be performed, both of which meant more money had to be spent.

"They (Department of Health and Human Services) didn't care if you were one horse or 20," Dr. Welk said referring to practice size.

Today Dr. Welk enjoys the advantages of being part of a larger operation. He doesn't like the fact he was more or less forced into the situation, however.

"The small rural practices are getting really creamed," he said. "It's a frustration that we can't handle anymore."

Dr. Welk's marriage with Arnett Clinic has enabled him to spend more time with patients. That doesn't necessarily translate into more income, though. Doctors such as Dr. Welk who sell their practices are just hoping to find a way to maintain their current income stream.

Although his association with Arnett Clinic has been good, Dr. Welk is uneasy about physicians who sell their practices to hospitals.

"Hospital entities buying practices, I have some concern about that," he said. "It's buying population, so to speak."

His speculation on that matter is one thing, but he said he doesn't need to guess about what is going to happen to private practices in non-metropolitan areas.

"The pure business solo practice will disappear," he said. "HMOs were the beginning. It's the same thing that happened to the small farmer. Rural America is going to lose the M.D.-type of

For those who may be thinking about selling their practices, Dr. Black has some advice. "Spend a long time talking," he said. "Make sure that getting along is part of the decision."

practice."

St. Vincent Hospital in Indianapolis is a newcomer in the area of acquiring primary care practices. The hospital began doing so about a year ago.

Mark Fritz, director of medical staff development, already sees a lot of good coming from the arrangements with 19 physicians at seven sites.

The physicians couldn't afford running an office anymore, he said. Now they are experiencing the efficiency coming from the operation of multiple practices. That has put doctors back to work as physicians instead of as businessmen.

The hospital itself is not receiving a direct benefit from the purchases, Fritz said. But there are indirect advantages that come from delivering primary care services. Doing so makes the hospital "kind of one-stop shopping. It helps us become more marketable."

What about critics who charge that hospitals that buy private practices are doing so to obtain sources for patients? Fritz stressed that isn't so at St. Vincent.

"Physicians can send their patients anywhere," he said. "It's even very clear in the contract our physicians can be on other hospitals' medical staffs. All we're doing is running the office."

As for a physician's income when the practice is sold, Fritz said St. Vincent Hospital's contracts are productivity-based, and income is determined on how much the doctor works.

"Theoretically, physicians' incomes should go up," he said.

Fritz said age doesn't seem to be a factor in a doctor's decision to sell a practice, although a year ago he would have said that the option was mainly for physicians near retirement.

"Now we have all ages," he said. "It's for anyone who says 'I'm tired of being a businessman.'" ❑

The author is the owner of MW Communications, an Indianapolis communications consulting company, and recently was named editor of Indiana Business Magazine.

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Physicians can help end the violence

Tina Sims
Managing Editor

Gary Babcoke, M.D., occasionally sees patients in his Chesterton family practice who have been abused by their spouses, but one particular case stands out in his memory.

He recalls a Porter County man who went on vacation in the South and "came home with a wife." The husband had severe psychiatric problems and threatened to kill his wife if she ever left him. After Dr. Babcoke heard about the abusive relationship, he decided to intervene. "I recognized it was a problem that needed to be dealt with appropriately," he said.

When Dr. Babcoke approached the man, in a nonjudgmental way, about his threats, he replied that he was not serious about them. The abuse continued, however, and Dr. Babcoke, fearing that the young woman's life was in danger, asked her if she knew someone who could get her to a safe place. With the help of her brothers, the woman fled while her husband was at work. Later, the husband committed suicide. "He was angry enough to take his own life," Dr. Babcoke recalls.

This example of spouse abuse is not uncommon. Domestic violence is the single largest cause of injury to women in the United States and has become such a concern to physicians that the American Medical Association launched a National Campaign Against Family Violence to educate physicians about the problem and help them address the problem in their communities. The Centers for Disease Control named family violence a major public health threat.

The Indiana State Medical Association also viewed family violence as enough of a health threat to adopt a resolution on the issue at the 1992 House of Delegates. The resolution calls for the ISMA and the ISMA Alliance to participate in the AMA's campaign against violence, by recommending establishment of local medical society violence prevention committees and by encouraging alliance members to join the National Coalition Against Violence. The resolution also asks that the ISMA, in cooperation with the alliance, encourage alliance members to develop programs to educate the public about the family violence problem, to support the victims of family violence and provide physicians with lists of resource assistance for patients who are family violence victims.

Physicians are often the first professional that a victim might turn to for assistance in ending their abuse by other family members. They are in a unique position to acknowledge the violence and assist patients in getting help. AMA research shows that 80% of Americans feel they could tell a physician if they had been either a victim or a perpetrator of family violence. The patient's trust is there. What's needed is information that the physician, who wants to let the patient know that nobody deserves to be abused, can use to assist that patient in contacting victim assistance agencies.

"Physicians play an integral role in addressing the problem," says Janet French, executive director of The Caring Place, a shelter-based program that serves victims of domestic violence and their children in Lake, Porter and Starke counties in northern Indiana. She encourages physicians to be aware of signs other than physical injuries that a patient may be abused, such as suspicions that an injury does not appear to be caused in the way the victim explained or a reluctance to respond to the physician's questions about her relationship with the abuser.

Physicians who suspect abuse are urged to calmly broach the subject with the victim. "Not to bring it up continues the thought that something is wrong with the victim," says French. She says physicians also should let the victim know that the abuse is not her fault.

Domestic violence is a "really complex problem," says French. Overcoming long-held notions about women's place in society remains one of the challenges to ending the violence. The United States was founded on old English law, which said men could beat their wives and viewed women as property, French explains. Many remnants of such beliefs persist in certain segments of society, contributing to the obstacles in preventing domestic abuse.

Violence in the home is also considered by many to be a private family matter, so outsiders often hesitate to get involved,

French says.

Dr. Babcoke is someone who does believe in getting involved. When he suspects abuse, he tries to get the patient to talk about the problem and then determine if she needs to get help. Getting information from patients may take time and gentle persuasion, but Dr. Babcoke has found some techniques that are effective in his practice. Questions should be asked in a non-threatening manner to put the patient at ease. He also tries to remain neutral, helpful and non-judgmental, unless he believes there's a definite danger, he says.

Because victims of abuse are often nervous and depressed, Dr. Babcoke says he tries to be especially gentle in his questioning. Victims feel shame and guilt, so they are not likely to volunteer information on an abusive home unless asked. He says that "Is everything going OK at home?" might be a more appropriate question than "Is your husband beating you?"

"You're just trying to be a problem solver," he says.

Dr. Babcoke understands why physicians do not always get involved in domestic issues, he says. Sometimes, physician intervention can result in both the abused and the abuser turning against the physician, he says. In other cases, physicians may believe that nothing will change as the result of their intervention.

One victim whose life did change as a result of physician intervention was Teresa Wilson of Valparaiso. An alcoholic and the product of a dysfunctional family, Wilson was married for eight and a half years to an abusive husband. The abuse escalated from verbal "put-downs" to hitting and forced sex, Wilson says. She accepted the abuse as normal behavior because she had seen her stepfather treat her mother that way.

Dr. Babcoke suspected abuse because Wilson had bruises and the frequency of her epileptic seizures had increased. He encouraged Wilson to discuss the problem with him, asking such questions as "Is there something you're not telling me?" and "How are things at home?"

Wilson finally left her husband three years ago when he began choking her and threatened to kill her. When Wilson showed up in Dr. Babcoke's office with a black eye and bruises on her face, he sent her to the hospital to determine if any head injuries had occurred and encouraged her to file a police report. He also referred her to a psychiatrist and recommended that she attend a co-dependency support group and a battered wives support group run by The Caring Place.

"I don't think I would have made it through the three years" without Dr. Babcoke, says Wilson.

Right questions can help abused

When physicians ask patients about abuse in their lives, the questions should be phrased in the physician's own words and in a nonjudgmental way. Here are some examples of recommended questions from the American Medical Association:

- Are you in a relationship in which you have been physically hurt or threatened by your partner? Have you ever been in such a relationship?
- Are you or have you ever been in a relationship in which you felt you were treated badly? In what ways?
- Has your partner ever destroyed things that you cared about?
- Has your partner ever threatened or abused your children?
- Has you partner ever forced you to have sex when you didn't want to? Does he ever force you to engage in sex that makes you feel uncomfortable?
- We all fight at home. What happens when you and your partner fight or disagree?
- Do you ever feel afraid of your partner?
- Has your partner ever prevented you from leaving the house, seeing friends, getting a job or continuing your education?
- You mentioned that your partner uses drugs/alcohol. How does he act when he is drinking or on drugs? Is he ever verbally or physically abusive?
- Do you have guns in your home? Has your partner ever threatened to use them when he was angry? ❑

The three years refers to the time she spent prosecuting her husband, from whom she is now divorced.

Although leaving her husband ended the physical abuse, she had other battles ahead. She and her two sons had to flee their home when a bullet went through the window. (No one could ever prove who fired the gun.) Her husband turned her family and friends against her. She had to fight laws that appeared to favor the accused. "You start feeling like you're being victimized by the system," she says.

Wilson encourages physicians to keep accurate and thorough records documenting any bruises or injuries on patients. Such evidence can help prosecute the abuser, she says. "Get educated about domestic violence," she urges physicians.

Because of the support from her physician, Wilson has been able to turn her life around. During her marriage, she had worked as a drama coach and as cleaning staff in a office building. Now she is a manager for Paul Harris, a women's clothing store.

She has become active as an advocate for legislation helping victims of abuse and designed a domestic violence button that is sold to raise money for the Caring Place in Valparaiso. The button features two eyes, one of which is blackened, and the message, "Indiana, It's Time to Stop Looking the Other Way When It Comes to Domestic Violence."

Wilson symbolizes a successful abuse survivor. With the help of physicians and other health care professionals, the violence may end for the other women and children who are still suffering. ❑

Referral information for victims

The following information may help physicians refer patients who are victims of domestic violence to the right agency or assistance program.

- Child Abuse – Child Protective Services. Call number under "County Government" in telephone directory.
- Adult Abuse Hotline. 1-800-992-6978.
- Indiana Coalition Against Domestic Violence. 1-800-332-7385. The number of this statewide referral network for programs to assist families affected by domestic violence is answered 24 hours a day.
- Victim Assistance Programs. Each county has a program to assist victims of any violent crime. The number is usually listed under the county prosecutor's office in the telephone directory. ❑

Alliance joins effort to end abuse

The Indiana State Medical Association Alliance is working to help victims of domestic violence.

Joann Wehlage and Diane Quinn, co-chairmen of the ISMA Alliance Health Promotions Committee, have selected domestic violence as the focus of their efforts this year. Their main goal is to provide physicians with information on resources available in their communities to help abuse victims.

Board members are working with county health promotions chairmen to help them compile such lists.

The alliance presented a program on domestic violence at its annual convention in April and will offer physicians statewide resources on domestic violence at an exhibit at the annual ISMA convention in October.

The Vanderburgh-Southwestern Medical Auxiliary has embarked on a two-year health project focusing on domestic violence, according to President-elect Shirley Becker. Speakers from two area shelters educated auxilians about abuse last year during talks at the monthly meetings. This year, the group is developing a comprehensive program to educate physicians about domestic violence and also plans to establish an advocacy program in which auxiliary volunteers would assist physicians in referring abused patients to the proper agency for help. ❑

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Violence among family members has reached staggering proportions. Every year more than 2 million cases of child abuse and neglect are reported, between 2 and 4 million women are battered by their spouses, and between 700,000 and 1.1 million of the elderly population are abused.

The American Medical Association has formed a *National Coalition of Physicians Against Family Violence*. Through the *Coalition* the American Medical Association hopes to involve you in activities that address issues of child abuse, sexual assualt, domestic violence and elder abuse because you have the unique ability to identify the symptoms, first-hand. By joining the *National Coalition* you will be showing your concern about the effects of family violence and victimization, and will become a committed advocate within your community for the prevention of family violence.

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Yes, include my name in the *Coalition's* membership

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Prophylactic knee braces for football: Do they work?

Gregory T. Hardin, M.D.
Jack Farr, M.D.
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Indianapolis

Abstract

Knee injuries in athletics are a major problem facing the sports medicine community. There is no compelling evidence to suggest that the likelihood of sustaining a knee injury is increasing; however, more knee injuries are being identified and treated due to improved diagnostic techniques. Successful prevention of knee injuries with prophylactic braces has not paralleled the substantial advances in diagnosis and treatment of these knee problems. This article summarizes the current data available and makes recommendations for subsequent prophylactic knee brace use.

Epidemiologic studies regarding the efficacy of prophylactic knee braces must take into consideration many variables. The ideal study should be randomized and prospective. Controls should be simultaneous rather than historical. Was the diagnosis established by a trainer and confirmed by a physician? Rule changes may negatively impact injury frequency/severity. What role did playing surface have on injuries? Shoe wear could be a factor, as some authors have noted increased of foot and ankle injuries. How was an injury defined or classified? Were thigh, lower leg, or foot and ankle injuries assessed? Did the study critically assess a difference in injury frequency and/or severity as it pertained to medial collateral ligament injuries, anterior cruciate ligament injuries, meniscal injuries or combined injuries? Was time missed defined (practice/week/game)? When studying the prophylactic knee brace literature currently available, one must ask these questions to critically determine the strength and deficiencies of the study.

Nowalski studied 20 patients who had anteroposterior radiographs of the knee with and without 40 pounds of valgus stress applied below the knee.[7] A second radiograph was obtained with the patient wearing a variety of lateral-sided prophylactic braces, hinged in the middle and offset from the knee. Less medial gaping of the braced knee was noted. This was the first published study evaluating prophylactic braces to protect from lateral applied knee forces.

The Anderson Knee Stabler Brace was developed in 1978 by George Anderson, head trainer of the Oakland Raiders, to protect medial collateral ligaments from re-injury.[2] Anderson's colleagues in the professional and college ranks were impressed with the reports of its effectiveness and began using it on their athletes who had sustained medial collateral ligament injuries. Subsequently, the medical staff of several teams decided that the brace could more importantly be used prophylactically. As the word about the potential to protect the medial collateral ligament spread, some were not careful to discern between medial collateral ligament and total knee protection. Considerable controversy remains on how effective these braces are in preventing such injuries.

Hewson et al,[6] Rovere et al, Paulos et al[8] and Teitz et al[15] have reported epidemiologic studies that have been nonsupportive in substantiating decreased incidence of medial collateral ligament and/or anterior cruciate ligament injuries when prophylactic knee braces are used *(Table)*.

A medical record review was presented by Hewson et al[6] concerning the University of Arizona intercollegiate football teams over an eight-year period (1977-1985). The nonbraced period was reviewed from 1977 to 1981. Following this, the Anderson Knee Stabler was mandatory for all practices and games for players at greatest risk, including linemen, linebackers, and tight ends, from 1981 to 1985. Results showed that the number, type and severity of knee injuries were similar for the braced and nonbraced groups.

Rovere et al performed a two-year study including all players on the Wake Forest Football team using the Anderson Knee Stabler prophylactically during practice and games.[11] A two-year nonbrace control period (two years prior) was also evaluated.

Grade I medial collateral ligament sprains accounted for 67% of injuries in the nonbrace period and 62% of the injuries in the brace period. During both periods, offensive team members, especially linemen, had the most knee injuries, and defensive backs the fewest. Brace use did not significantly alter the relative frequency of injuries by player or position. This study concluded that the Anderson Knee Stabler was ineffective for prophylaxis. Knee injuries were more common when braces were worn. Since brace wear was also associated with leg cramping and added financial expenditures, the authors concluded that they could not recommend the use of a prophylactic knee brace without further study.

Teitz et al used the members of Division I of the National Collegiate Athletic Association (NCAA) as its study population.[15] Their results showed that in 1984 and 1985, players who wore prophylactic knee braces had a significantly higher injury rate than unbraced players. Player position, playing surface, mechanism of injury or type of brace did not affect the rates of injury.

Injuries were more common during contact and at every skill level among those who wore braces. Tietz et al concluded that they would not advise preventive knee bracing among college football players.[15]

Paulos et al, in a biomechanical study using prophylactic knee braces with fresh-frozen cadaveric knees, measured ligament tension and joint displacement at static, nondestructive valgus forces and at low-rated destructive forces.[9] In Part I of their study, no significant protection could be docu-

Table

Summary of principal scientific investigation

SUPPORTIVE	
Hansen	Four-year USC injury review showed reduction injuries and surgery for braced.
Schriner	Review of 25 Michigan high schools found 5% injury rate for unbraced players and no injuries for braced.
Taft	University of North Carolina study, three years before bracing (no braces) and three years after (100%) braces, showed some injury reduction and significant severity reduction (Grade III down 70%).
Paulos	Braces that increased impact duration protect ACL more than MCL. Most braces provide some degree of protection to the ACL with direct lateral impact.
Sitler	Most highly controlled. Prospective two-year study of 1,396 West Point cadets. Braced defensive players had a significant decrease in number, but not severity, of knee injuries. No difference in foot and ankle injuries.
NON-SUPPORTIVE	
Hewson	Reduction in injury frequency and severity at Arizona due to better care, not braces.
Rovere	Increase in MCL strains and and ACL tears during bracing at Wake Forest.
Teitz	Division I team survey showed braced players had more injuries than non-braced.
Paulos	Biomechanical testing suggested potential preloading of MCL. Now stated as clinically insignificant.
Baker	Biomechanical testing showed reduction in abduction angle using functional brace but little or no protection with prophylactic braces.
Garrick	Evaluated six studies finding significant methodological problems and conflicting results. "Impossible to state with assurance the role of prophylactic knee bracing at this time."
Grace	Two-year high school study showed four times more knee injuries in the braced group. Dramatic increase in foot and ankle injuries in braced group (3 x).[2]

mented with the two preventive braces used. Also, four potentially adverse effects were noted: medial collateral ligament preloading, center axis shift, premature joint line contact and brace slippage. In part II of their study, brace-induced medial collateral ligament pre-load in vivo was negated by joint compressive forces.[10] In summary, Paulos et al [8-10] concluded that most prophylactic knee braces presently available are biomechanically inadequate.

Scientific investigators supporting the use of prophylactic knee bracing include Hansen et al,[5] involving players on the University of Southern California football team from 1980 to 1984. These authors concluded that prophylactic knee bracing was better than no bracing in reducing injuries and surgery.

The University of North Carolina study was reported by Taft et al.[14] This study documented the football team's experience from 1980 through 1982, when no braces were used, and from 1983 through 1985, when all team members were required to wear prophylactic knee braces. These authors concluded that bracing was helpful in decreasing the severity and frequency of knee injuries.

Schriner et al reported a survey of 1,246 players from 25 high schools in Michigan during the 1984 football season.[12] Diagnoses were made by physicians as reported by coaches, and only knee injuries from lateral forces and hyperextension were analyzed. They found a 5% injury rate for unbraced players and no injuries for braced players.

Recently, two prospective, randomized studies evaluated prophylactic knee braces resulting in contradictory conclusions.[4,13] Grace et al[4] evaluated 580 high school football players over a two-year period. The prophylactic knee braced athletes had a significantly higher knee injury rate ($p<0.001$) and foot and ankle injury rate ($p<0.01$). Their results questioned the efficacy of prophylactic knee braces and called attention to their potential adverse effects on adjacent distal joints.

A study by Sitler et al[13] from West Point noted a decrease in frequency but not the severity of knee injuries with prophylactic brace use. This prospective two-year study evaluated 1,396 intramural tackle football players with an average age of 19.3 years. Seven hundred five controls and 691 braced athletes were involved. A significant decrease in frequency and total number of medial collateral ligament knee injuries was noted in braced defensive, but not braced offensive, players. Retrospectively, they assessed all players for foot and ankle injuries and noted no significant differences between the two groups.

Prophylactic knee bracing remains controversial. They have not consistently been shown to prevent or reduce the severity of injuries to the anterior cruciate ligament or menisci. Several studies have shown a trend toward a reduced incidence of these injuries. With the exception of the West Point Study,[13] most have overgeneralized and cannot document that prophylactic knee braces are the cause of increased or decreased injuries.

The American Academy of Pediatrics went even further with its position, recommending that prophylactic lateral knee bracing not be considered standard equipment for football players because of lack of efficacy and the potential of actually causing harm.

The American Academy of Orthopaedic Surgeons in 1985 stated, "Efforts need to be made to eliminate the unsubstantiated claims of currently available prophylactic knee braces and to curtail the inevitable misuse, unnecessary costs, and medical/legal problems."[1]

The American Orthopaedic Society for Sports Medicine and *The Journal of Bone and Joint Surgery* (in an editorial, January 1987), have taken the same position. The American Academy of Pediatrics went even further with its position, recommending that prophylactic lateral knee bracing not be considered standard equipment for football players because of lack of efficacy and the potential of actually causing harm.

Conclusion

Prophylactic knee braces remain controversial and, for the most

part, have been shown to be ineffective in preventing knee injuries in collegiate and high school players. Most studies have design flaws and bias, and therefore no conclusions can be drawn at this time. Mandatory prophylactic knee bracing cannot be recommended until further prospective and biomechanical studies can demonstrate otherwise. ❑

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References

1. American Academy of Orthopaedic Surgeons: Knee Braces. Seminar Report, Chicago, Ill: CV Mosby; 1985.

2. Anderson G, Zeman SC, Rosenfeld RT: The Anderson Knee Stabler. *Phys Sports Med*, 7:125-127, 1979.

3. Baker BE, VanHanswyk E, Bogosian S, et al: The effect of knee braces on lateral impact loading of the knee. *Am J Sports Med*, 17:182-186, 1989.

4. Grace TG, Skipper BJ, Newberry JC, et al: Prophylactic knee braces and injury to the lower extremity. *J Bone Joint Surg*, 70-A(3): 422-427, 1988.

5. Hansen BL, Ward JC, Diehl RC: The preventive use of the Anderson Knee Stabler. *Phys Sports Med*, 13:75-81, 1985.

6. Hewson GF, Mendini RA, Wang JB: Prophylactic knee bracing in college football. *Am J Sports Med*, 14:262-266, 1986.

7. Nowalski ED: Alternative methods of knee stabilization in sports: A comparative analysis. *J Canadian Athletic Therapists Assn*, 5:13-17, 1978.

8. Paulos LE, Drawbert JP, France EP: Lateral knee braces in football: Do they prevent injury? *The Physician and Sports Medicine*, 14:119-124, 1986.

9. Paulos LE, France EP, Rosenberg TD, et al: The biomechanics of lateral knee bracing – Part I: Response of valgus restraints to loading. *Am J Sports Med*, 15:419-428, 1987.

10. Paulos LE, France EP, Rosenberg TD, et al: The biomechanics of lateral knee bracing-Part II: Impact response of the braced knee. *Am J Sports Med*, 15:430-438, 1987.

11. Rovere GD, Haupt HA, Yates CS: Prophylactic knee bracing in college football. *Am J Sports Med*, 15:111-116, 1987.

12. Schriner JL, Schriner DK: The effectiveness of knee bracing in high school athletes. Presented at AAOS Meeting; Jan. 22, 1987; San Francisco, Calif.

13. Sitler M, Ryan J, Hopkinson W, et al: The efficacy of a prophylactic knee brace to reduce knee injuries in football. *Am J Sports Med*, 18(3):310-315, 1990.

14. Taft TN, Hunter SL, Funderburk CH: Preventative lateral knee bracing in football. Presented at the 11th Annual Meeting of the American Orthopaedic Society for Sports Medicine; July 1985; Nashville, Tenn.

15. Teitz CC, Hermanson BK, Kronmal RA, et al: Evaluation of prophylactic braces to prevent injury to the knee in collegiate football players. *J Bone Joint Surg*, 69(A):2-9, 1987.

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The most common mistake people make is to fully maximize the unlimited marital deduction without regard to the unified credit. By leaving all of the property to your spouse, you are not taking advantage of the credit. Upon the death of the surviving spouse, the beneficiary of the estate will pay a higher tax on the estate than necessary because one of the credits has not been used.

Estate tax planning strategies can best be addressed through the use of trusts. A trust allows you to leave the $600,000 of property ultimately to your children, with your spouse having limited access to it during the spouse's lifetime. A trust allows you to address the needs of your spouse while taking advantage of the unified credit at the death of both you and your spouse. This arrangement is called a family, unified credit or "B" trust. Estates greater than $1.2 million can use other types of estate planning techniques to reduce the amount of estate tax liability.

The proper estate planning legal documents, drafted by an attorney, are just one step in coordinating your overall estate plan. You also should take steps to minimize the impact of estate taxes that remain after proper documents have been prepared. ❑

The author welcomes readers' questions. He can be reached at 1-800-262-3863.



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Orchids blossom under surgeon's care

Tina Sims
Managing Editor

Eldon Gerig, M.D., finds that his surgical skills come in handy in the greenhouse.

As an orchid grower in his spare time, Dr. Gerig knows that sterile techniques are crucial to success in surgery as well as in horticulture. The Mishawaka surgeon also is aware that he must be committed and ready for challenges in both fields.

Dr. Gerig first started growing orchids more than 10 years ago, after friends in Puerto Rico sent the Gerigs home from a visit with some of the orchid plants. Although he had always been interested in plants and flowers, Dr. Gerig had never tried cultivating orchids, so he was intrigued by the challenge.

He started with a few orchids under lights in his basement but soon saw a need to expand. A greenhouse was added to the rear of the house to accommodate his blossoming hobby. Now he has outgrown that greenhouse, so the new home that the Gerigs are building will include an even larger greenhouse.



Dr. Gerig shows off some of the orchids blooming in his greenhouse.

The greenhouse features an automatic misting system and a unit that automatically injects fertilizer into the watering system. It's heated by an underground hot water system that keeps the temperature above 60 degrees.

His collection of more than 500 orchids includes at least 50 species out of the more than 20,000 species that are available. "There are so many different kinds. That's what makes it interesting," says Dr. Gerig.

Because it takes five years for some of the orchids to bloom, he also enjoys the surprise element involved. Getting them to bloom, however, can sometimes present a challenge. "You have to be committed to it," says Dr. Gerig. When a plant refuses to bloom, he moves it to a new location in the greenhouse, hoping that a different light or temperature will spur flowering. "Usually I can get them to bloom," he says.

"You have to know the culture of each one," he says of his plants. "You can't treat them all alike." Orchids vary in their light, temperature and moisture requirements. Most orchids, however, are similar in that they need to be potted in a coarse media such as bark mix, not soil, although there are a few terrestrial orchids, he points out.

Modern technology helps Dr. Gerig tend for his plants. He keeps a record on a home computer of his orchids according to light and temperature requirements.

Beetles and snails can pose a threat to orchids, so "you have to keep after them" to prevent the insects from mutilating the plants and blooms, says Dr. Gerig.

Because orchids have such a long life span, viruses – "the scourge of the orchids" – can be even more of a problem, he says. If an orchid is attacked by a virus, "you might as well throw it away."

He shares the beauty of his hobby with his office and his church. Each week, he prepares an arrangement of blooming orchids to decorate his office. He also takes floral displays to the Kern Road Mennonite Church for the enjoyment of other church members.

One orchid in his office caught the eye of the woman who was designing an informational brochure on Dr. Gerig's practice. She liked it so much she used a close-up color photo of the Phalaenopsis on the cover of the brochure.

Always eager to educate himself further on his hobby, Dr. Gerig has a sizeable collection of orchid books and is a member of the Michiana Orchid Society. The society's monthly meetings feature guest speakers, "bring and brag" sessions and tours of greenhouses, including Dr. Gerig's.

He also learns by participating in orchid shows in which entries are judged. He is especially proud of the best of class award he won for best Dendrobium at the 1986 Illinois Orchid Society Mid-America Show in Chicago. He faced stiff competition there, including entries from Hawaii, where orchids grow wild.

Dr. Gerig has considered becoming an orchid show judge, a position that requires five to eight years of training. He also may try hybridization, a process he says would be easy with his background as a surgeon.

His roots are actually in the soil. He grew up as an "Iowa farm boy" and graduated from the State University of Iowa Medical School. Even before he started growing orchids, he was always interested in plants and has completed a landscaping course.

He and his wife, whom he met at Goshen College, have lived in Mishawaka since 1962. His three children followed him into medicine; two sons, Winston Gerig, M.D., and Kevin Gerig, M.D., are surgeons in practice with him, and his daughter, Nita Gerig, M.D., is a pathology resident at the Indiana University School of Medicine. ❑

Wanted: Physicians to profile

Do you know a physician with a particularly interesting or unusual hobby or pursuit outside of medicine? INDIANA MEDICINE wants your suggestions on people to consider featuring in its regular series of profiles of physicians who have found rewarding ways to fill their leisure time.

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Mail, call in or fax your suggestions to Tina Sims, Managing Editor, INDIANA MEDICINE , 322 Canal Walk, Indianapolis, IN 46202, (317) 261-2060 or 1-800-257-4762, fax (317) 261-2076. ❑

Common insurer creates potential conflict of interest

Editor's note: This report was submitted by the Indiana State Medical Association/Physicians Insurance Co. of Indiana Task Force.

Indiana physicians should be aware of the potential dangers of a common insurer for a hospital and its staff physicians.

Hospital professional liability insurers are not prohibited from also offering coverage to physicians, nor are physician insurers barred from also marketing policies to hospitals. Several large national insurers and physician-owned insurers in several states have units serving both market audiences.

Nonetheless, if a hospital insurer focuses on staff physicians and places marketing emphasis on the theoretical advantages of a common insurer, i.e., economies in claims services, premium discounts, various combined programs or premium discounts, physicians should be aware of potentially serious conflicts of interest.

The responsibility of an employer for the negligent acts of an employee is well established in case law. This applies to hospitals and their employees, including any employed physicians; however, private physicians who have staff privileges or an independent contractor relationship as an individual, group or corporation, are not employees in the legal sense. Those physicians remain legally liable for their negligent acts. In many instances, including claims involving the physician and an employee of the hospital, claims services and defense from a common insurer may not only be inappropriate for the insured physician, it may be injurious.

Physicians have a legitimate concern over the common insurer's pragmatic evaluation of the relative importance of the interests of one physician policyholder as opposed to a hospital policyholder whose annual premium obviously is many times greater. Additionally, claims philosophies and objectives may conflict. Hospitals may agree to a quick settlement of relatively minor claims, whereas physicians desire firm opposition to unfounded claims to protect their professional reputations.

Certainly legal precedents are changing, but one tenet remains clear and firm: the individual responsibility of the physicians to uphold the prevailing standard of care.

Many hospitals self-insure up to certain limits of exposure and assume responsibility for settlement decisions for claims under that amount. In such instances, the common insurer could support a nuisance settlement since it would be financially responsible only for the physician's portion. Today, physicians could find their individual claims records in the National Practitioner Data Bank adversely impacted by the desire of the hospital and/or common insurer to settle, rather than fight.

Another potential disadvantage for physicians sharing coverage with a hospital's insurer could include the loss of premium discounts for loss-free experience and/or effective risk management, assuming the insurer offers such discounts.

Changes within the health insurance industry, which could be magnified and expanded by legislated health care reforms, already are spawning new contractual and professional relationships among physicians, hospitals, PPOs, HMOs, managed care plans and purchasers of health services. New issues of legal liability are arising. Historic legal doctrines are being challenged. Courts have recognized that health care providers, even while serving in an employed status, have individual liability for patient injury caused by their failure or refusal to follow specific guidelines or instructions. Although employers are liable for the acts of employees, they also have the legal right to sue negligent employees to recover damages. Private physicians have been declared agents of hospitals with which they have an independent contractor relationship. In turn, hospitals have been held liable for the performance of private physicians whose services they actively promoted and advertised. Man-

aged care plans that set forth specific practice parameters and become involved in treatment decisions assume liability for their actions, but the participating physician's duty to perform within the prevailing standard of care is not lessened.

The Clinton administration's task force on health care reform is addressing the issue of medical malpractice by exploring a concept called enterprise liability. This untested approach would transfer all liability from individuals to the accountable health plan. The basis of liability would still be the acts of the practitioner or provider, thus raising serious questions of constitutional rights. Further, there is no evidence that this approach would either reduce the incidence of claims or the substantial legal costs associated with malpractice claims and suits. Indeed, patients might well be more inclined to sue the faceless, deep-pocketed health care plan than the physicians with whom they have a personal relationship. Enterprise liability is seen by many as a boon for trial attorneys and a curse for physicians and other health care professionals whose professional futures could be marred by unwarranted allegations of negligence.

For all of the above reasons, it is important that Indiana's private physicians insist on high-quality coverage that focuses specifically on themselves and their corporate entities. To be certain that your interests are not secondary, your coverage should not be tied to, allied with or dependent on any coverage provided by your insurer to a hospital or any other health care entity. A common insurer can create problems not only with claims services, but with rate levels, underwriting acceptability, risk classification, risk management services, the insurer's long-term commitment to your protection – and even your future ability to practice medicine in the setting of your choice.

For additional information, contact the ISMA/PICI Task Force or the PICI Customer Service Department. ❑



Patent ductus arteriosus in neonates

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Abstract

Patency of the ductus arteriosus is one of the more common problems of the neonate. Although the ductus arteriosus usually closes within the first days of life, persistent patency can complicate the clinical status of a newborn. The ductus arteriosus also may play a role in the pathophysiology of persistent pulmonary hypertension of the newborn and in some forms of congenital heart disease. Diagnosis of patent ductus arteriosus can be suspected clinically but should be verified by echocardiography before treatment. Accurate diagnosis, early intervention and proper treatment are necessary to decrease the immediate risks and minimize the potential for long-term complications.

The postnatal period is a time of transition from a fetal circulatory pattern to that of the newborn. The neonate is at risk for several cardiovascular abnormalities, the most common being the patent ductus arteriosus. This article will review the embryology and anatomy of the ductus arteriosus and discuss its clinical implications with a focus on physiology and pathophysiology. Finally, we will review current treatment considerations in the preterm infant and infants with cyanotic congenital heart disease.

Embryology, anatomy and physiology of the ductus arteriosus

The ductus arteriosus is embryologically derived from the sixth embryonic arches, which are identifiable during the sixth and seventh week postconception. The sixth embryonic arches appear as vascular communications between the aortic sac and dorsal aorta *(Figure 1)*. The aorta and the pulmonary artery are formed during septation of the truncus arteriosus. At this time, the sixth embryonic arches appear contiguous with the pulmonary artery. The ventral portion of the right arch becomes the proximal portion of the pulmonary artery while the dorsal portion regresses. The ventral portion of the left arch is absorbed into the pulmonary trunk, and the dorsal segment becomes the ductus arteriosus *(Figure 1)*.[1,2]

Histologically, the ductus arteriosus differs from both the aorta and the pulmonary artery. The aorta and pulmonary artery are classified as elastic arteries, whereas the ductus arteriosus is considered a muscular artery. The ductus arteriosus develops during fetal life from a single layer of elastic fibers and a single layer of flattened endothelial cells[3] into a structure that contains spirals of smooth muscle cells, a large amount of loosely organized ground substance and very few elastic fibers. The structure of the ductus arteriosus at term is conducive to development of infolding and obliteration after birth.

Patency of the ductus arteriosus during fetal development is important for delivery of oxygen and nutrients from the placenta. Blood oxygenated in the placenta flows through the umbilical vein to the ductus venosus. The blood then flows into the inferior vena cava before entering the right side of the heart, where it mixes with venous blood from the superior vena cava *(Figure 2)*. Because fetal pulmonary vascular resistance is greater than systemic vascular resistance and due to anatomic features of the right atrium, the relatively well oxygenated blood from the right atrium is diverted from the pulmonary artery across the patent foramen ovale and ductus arteriosus to the left side of the heart and aorta; blood with higher nutrient and oxygen content is thereby supplied to body tissues.

Patency of the ductus arteriosus is maintained through an active process. Prostaglandin E_2 and

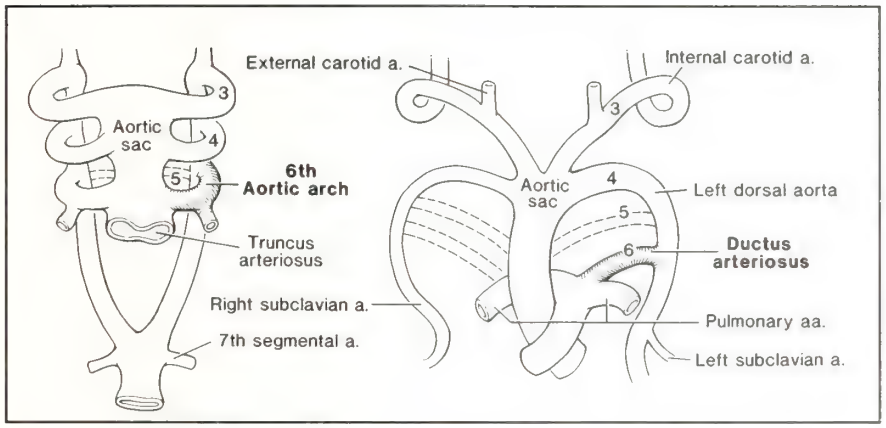


Figure 1: The development of the ductus arteriosus from the sixth embryonic arches.

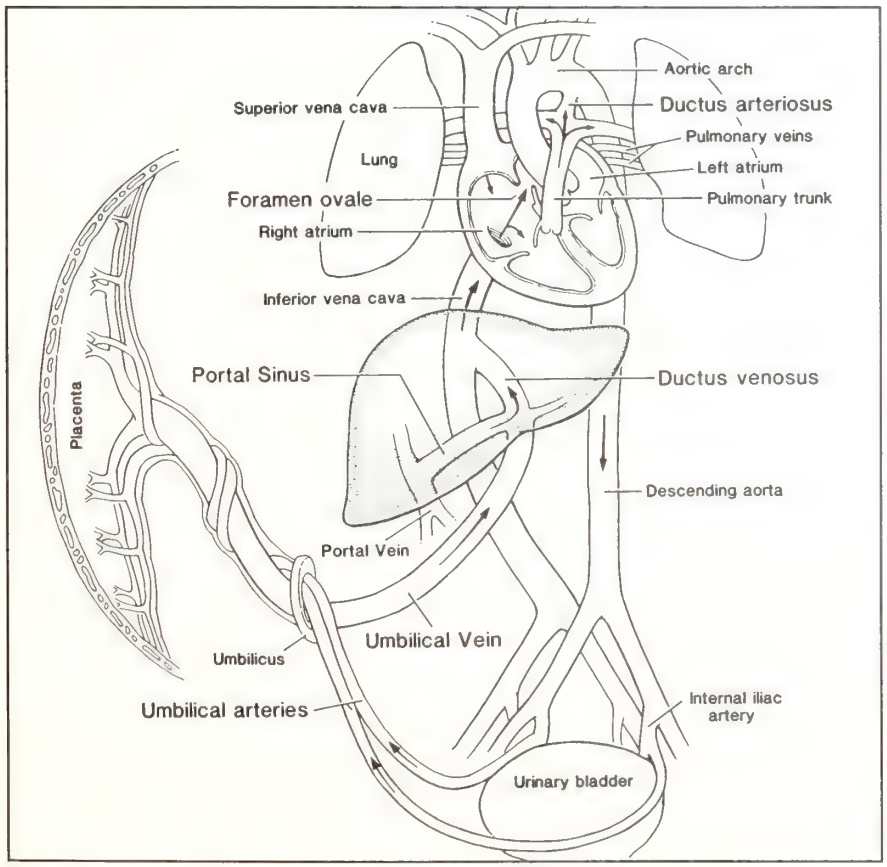


Figure 2: The fetal circulation is characterized by the presence of anatomic shunts between the pulmonary circulation and the systemic circulation (the ductus arteriosus and the foramen ovale).

the relative hypoxemia of the fetus are believed to be the principal active agents responsible for maintaining patency.[4] In the fetus and preterm infant, decreased plasma clearance and metabolism result in elevated levels of prostaglandin E_2. Increased sensitivity of ductal tissue to the vasodilating action of prostaglandin E_2 and elevated prostaglandin E_2 levels are thought to be the major factors contributing to persistent and recurrent ductal patency in preterm infants. The major source of prostaglandin E_2 during fetal life is unknown. Intramural production of this prostaglandin has been demonstrated, but other possible sources include the placenta and other endothelial surfaces. The oxygen tension of umbilical venous blood is approximately 30 Torr. This relative hypoxemia may contribute to ductal patency indirectly by blunting the oxygen stimulus for ductal closure. Other vasoactive substances, including prostacyclin and adenosine, may also contribute to ductal patency in the fetus although the significance of their roles has yet to be explained.[1,5-9]

At birth, the increase in blood oxygen tension traversing the ductus arteriosus is thought to be the principal stimulus necessary to initiate ductal contraction. It is not yet clear whether oxygen is a direct stimulus, requires as yet unidentified vasoactive mediators (e.g., thromboxanes, adenosine triphosphate, bradykinin, histamine, acetylcholine) or potentiates other mediators (neural and hormonal agents) to induce ductal closure.[6,10]

In the normal full-term infant at birth, functional closure of the ductus occurs with contraction of the smooth muscle fibers and is followed by coalescence of the

Table 1

Clinical manifestations of the patent ductus arteriosus with left-to-right shunting

- Tachypnea
- Tachycardia
- Hepatomegaly
- Decreased peripheral perfusion
- Bounding peripheral pulses
- Widened pulse pressure
- Hyperdynamic precordium
- ± Systolic murmur
- Apnea
- Cardiomegaly and increased pulmonary vasculature on chest radiograph
- Increased oxygen requirement and ventilatory needs

Table 2

Clinical manifestation of the patent ductus arteriosus with right-to-left shunting

- Cyanosis (greater in lower extremities if shunting across a patent ductus arteriosus)
- ± Systolic murmur
- Pre-and post-ductal oxygen tension difference greater than 10%
- Impairment and lability of oxygenation
- Decreased pulmonary vasculature on chest radiograph

mucoid intramural substance, ischemia, cytonecrosis and fibrotic transformation to the ligamentum arteriosus. Functional closure of the ductus arteriosus usually occurs in the first one to two days of life, but the potential for the ductus arteriosus to reopen may persist for an additional seven days.[10,11] In premature infants, ductal closure usually occurs later and prolonged patency is common; this may result from the persistent sensitivity of the preterm infant's ductus arteriosus to hypoxemia and circulating prostaglandin E_2.

Closure of the ductus arteriosus is important for transition to the postnatal circulation in all neonates, including those born near term. In utero closure of the ductus arteriosus may be complicated by development of fetal pulmonary hypertension secondary to an increase in pulmonary vascular muscle development; this may precipitate the clinical findings of persistent pulmonary hypertension of the neonate after delivery.[12,13] For this reason, pregnant women should not take medications that inhibit prostaglandin production, such as aspirin and indomethacin.

Clinical presentation

The clinical manifestations of patent ductus arteriosus can be categorized according to the direction of blood flow through the ductus. Nineteen percent of low-birthweight infants will develop evidence of increased left-to-right shunting through the ductus during the first two weeks of life.[14] In these infants, pulmonary arterial pressure falls below systemic arterial pressure, and blood flow is increased to the pulmonary vasculature. These infants may demonstrate effects of pulmonary vascular volume overload, such as tachypnea, tachycardia, hepatomegaly and decreased perfusion.[15] In many infants, especially those born prematurely, initial signs may include bounding peripheral pulses, widened pulse pressure, low diastolic blood pressure and a hyperdynamic precordium *(Table 1)*.

A systolic ejection murmur at the upper left sternal border is the most common auscultatory finding in the premature infant. Chest radiographs often demonstrate cardiomegaly with increased pulmonary vasculature. Infants may have increased oxygen requirements and ventilatory needs as a result of decreased lung compliance and pulmonary edema. The procedure of choice for positive diagnosis of patent ductus arteriosus and exclusion of ductal dependent cardiovascular lesions is color flow Doppler echocardiography; someone experienced in color flow Doppler echocardiography should perform this procedure. The cardiac anatomy should be visualized to obtain the best possible view of the ductus and the color-enhanced flows through the ductus. The descending aorta in the ductal region should be carefully visualized to exclude masked periductal coarctation of the aorta.

Right-to-left shunting through the ductus arteriosus and/or patent foramen ovale results in decreased blood flow to the lungs. This phenomenon may occur in term and near-term neonates with persistent pulmonary hypertension of the newborn (persistent fetal circulation). For these infants, increased pulmonary

Table 3

Complications of untreated patent ductus arteriosus in the neonate

Cardiopulmonary	Pulmonary edema Decreased lung compliance Cardiac volume overload Myocardial insufficiency
Gastrointestinal	Necrotizing enterocolitis
Renal	Renal insufficiency
Central nervous system	Possible intraventricular hemorrhage

vasoreactivity increases pulmonary arterial pressure, which precipitates right-to-left shunting. Oxygenation is impaired, and oxygen lability is characteristic *(Table 2)*. On physical examination, a systolic murmur may be noted and cyanosis is often present. Right-to-left shunting at the ductal level may be demonstrated by lower oxygen saturations in the lower extremities than in the right upper extremity or head. Right-to-left shunting at the atrial level will not show this discrepancy. Chest radiographs often demonstrate decreased pulmonary vasculature. Differentiating whether a cyanotic neonate is suffering from severe persistent pulmonary hypertension or cyanotic congenital heart disease may be difficult, and referral to a tertiary center is usually recommended.

Complications

Clinical complications of a patent ductus arteriosus with left-to-right shunting are usually the result of one of two mechanisms. First, problems with pulmonary gas exchange, related to increased pulmonary edema, are manifest as respiratory distress, recurrent apnea and/or ventilatory failure and may be superimposed on the atelectasis associated with hyaline membrane disease.[15] These problems may result in prolonged exposure to barotrauma and high-inspired oxygen with subsequent development of parenchymal lung damage and chronic lung disease (bronchopulmonary dysplasia).

The second mechanism responsible for complications of patent ductus arteriosus is related to a "vascular steal" phenomenon with an associated tissue hypoperfusion/reperfusion injury. In the gastrointestinal tract, this mechanism may be manifest initially as feeding intolerance. Significant shunting across the ductus arteriosus along with high intestinal intraluminal solute load, intermittent reperfusion of the intestinal vascular bed, and bacteremia are believed to be risk factors for development of necrotizing enterocolitis.[16,17] The kidneys are also sensitive to ductal shunt associated hypoperfusion with development of renal insufficiency, or failure in the most extreme cases. In the central nervous system, hypoxemia, acidemia and perturbation of autoregulatory responses as consequences of changes in cerebral perfusion may precipitate intraventricular hemorrhage.[18] Persistent metabolic acidosis and myocardial insufficiency secondary to diminished coronary artery perfusion in the presence of increased cardiac work may also complicate the presence of patent ductus arteriosus with a large left-to-right shunt *(Table 3)*.

Table 4

Management of patent ductus arteriosus

- Fluid restriction
- Diuretic therapy
- Oxygen
- Ventilatory support
- ± Inotropes
- Indomethacin
- Surgical ligation

Treatment

Because persistent or recurrent patency of the ductus arteriosus is a common problem in low-birthweight infants and potentially associated with several life threatening complications, treatment is usually recommended when left-to-right ductal flow is of hemodynamic significance and before the onset of complications *(Table 4)*.

The initial management of a premature infant with a hemody-

Table 5

Indomethacin dosing*

Age	1st dose	2nd and 3rd dose
< 48 hrs	0.2 mg/kg	0.1 mg/kg
2-7 days	0.2 mg/kg	0.2 mg/kg
> 8 days	0.2 mg/kg	0.25 mg/kg

**12-hour intervals between doses are recommended.*

namically significant patent ductus arteriosus may include oxygen administration and mechanical ventilation with emphasis on maintaining a relatively high-end distending pressure (5-7 cmH_20). In addition, fluid restriction and diuretic therapy are often used.[19] By reducing intravascular volume, pulmonary edema may be reduced through reduction in left ventricular end-diastolic pressure and increased plasma oncotic pressure within the pulmonary arterioles. Reduction of the hydrostatic pressure gradient across the ductus arteriosus with reduction in intravascular volume may also contribute to decreased pulmonary edema and ductal closure. With decreased pulmonary edema, lung compliance may improve and allow reduction in ventilatory support and oxygen requirement. In our experience, fluid restriction and diuretic therapy alone are infrequently effective in achieving ductal closure.

Cardiac glycosides (e.g., digoxin) are not part of the routine management of patent ductus arteriosus. Myocardial contractility in the premature infant appears to be maximal, obviating the need for further inotropic support. In addition, there is a higher incidence of arrhythmias and subendocardial ischemia in infants treated with digoxin.[20] McGrath studied the effect of digoxin in infants with and without fluid restriction and concluded that digoxin did not affect outcome.[21] Occasionally, inotropes such as dopamine or dobutamine may be helpful in maintaining adequate cardiac output until ductal closure is completed. However, the level of inotropic activity must be weighed against the potential for increased system vascular resistance which may result in increased left-to-right shunting across the patent ductus and systemic hypotension.

Indomethacin is often used to treat the premature infant with symptomatic patent ductus arteriosus. The initial dose of indomethacin is usually 0.2 mg/kg given intravenously. Doses are usually scheduled at 12-hour intervals for three doses *(Table 5)*. An increase in dose related to age is based on the increase in clearance of indomethacin with age. Some researchers have advocated following indomethacin levels[22,23] but difficulties obtaining these levels in a timely manner preclude their use in many institutions. We prefer intravenous administration rather than enteral administration of indomethacin due to potential for gastric hemorrhage and perforation with the enteral route.[24]

In addition to the beneficial effects on closure of the patent ductus arteriosus, indomethacin also may produce undesirable side effects. Transient renal insufficiency frequently follows administration of indomethacin. This effect is related, at least in part, to vasopressin release.[25] Indomethacin depresses prostaglandin synthesis, thereby decreasing the inhibitory action of prostaglandins on vasopressin. Renal insufficiency associated with indomethacin may be manifested by oliguria (urine output ≤0.6 cc/kg/hour), azotemia (BUN >29 mg/dL), increased serum creatinine levels (>1.7 mg/dL), decreased free water clearance and decreased fractional excretion of sodium and chloride. In addition, hyponatremia may occur secondary to congestive heart failure, renal hypoperfusion and

Table 6

Relative contraindications to indomethacin

- Oliguria
- Azotemia
- Elevated serum creatinine
- Thrombocytopenia
- Bleeding diathesis
- Recent intraventricular hemorrhage
- Necrotizing enterocolitis
- Hyperbilirubinemia

potentiation of antidiuretic hormone action. These effects appear to be transient, with return to normal function within several days of stopping indomethacin.

Inhibition of prostaglandin production by indomethacin may decrease platelet aggregation, an effect that may last longer than one week.[25] Because of this effect and possible contribution to development of intracranial hemorrhage, Gersony and colleagues did not administer indomethacin during the national collaborative trial in the presence of intracranial hemorrhage within the preceding seven days.[26] Although the effect of indomethacin on platelet aggregation may increase the risk of intracranial hemorrhage in preterm infants, the relative significance of this effect has recently been questioned. Several investigators have concluded that indomethacin may actually decrease the risk of intracranial hemorrhage in preterm infants[27-29]; therefore, administration of indomethacin during an active intracranial hemorrhage must be carefully considered by the clinician. In light of these complications, indomethacin may be contraindicated in the presence of acute renal failure, oliguria, elevated creatinine, azotemia, thrombocytopenia, bleeding diatheses, hematochezia, recent intracranial hemorrhage (within seven days), necrotizing enterocolitis or hyperbilirubinemia *(Table 6)*. Urinary output, weight, platelet count, serum creatinine, blood urea nitrogen and electrolytes should be monitored during administration of indomethacin. In addition, infants should be observed for signs of intracranial hemorrhage, gastrointestinal bleeding and feeding intolerance. We often discontinue feedings during the course of indomethacin administration.

Although most studies have demonstrated that the optimal time for indomethacin-induced ductal closure is before 14 days of age, there are case reports of successful ductal closure in which indomethacin has been given to infants older than 20 days of age with hemodynamically significant patent ductus.[30] Infants younger than 34 weeks gestation may retain enough sensitivity to indomethacin that it may be reasonable to consider repeating a course of indomethacin once or twice in infants younger than 34 weeks postconceptual age before surgical intervention.[31]

There is no advantage to treating infants born prematurely with indomethacin before the development of clinical evidence for patent ductus arteriosus.[32,33] Mahoney et al enrolled 104 infants with birth weights between 700 and 1300 g in a double-blind controlled trial to determine whether treatment with indomethacin on the first day of life altered morbidity in very low-birthweight infants.[32] There was a decreased incidence of large left-to-right shunts through a patent ductus arteriosus, but there was no demonstrable decrease in long-term morbidity or outcomes.

After therapy with indomethacin, some infants will have recurrent patency of the ductus arteriosus. Recurrence is probably related to several factors associated with very low-birthweight and extreme prematurity. First, continued production of vasodilatory prostaglandins after administration of indomethacin may induce relaxation of the previously constricted ductus.[34] Second, in premature infants with lower gestational ages, the ductus arteriosus appears more sensitive to the vasodilatory effects of circulating prostaglandin E_2.[7] Third, since obliteration of the ductal lumen requires sustained constriction of smooth muscle and fibrotic transformation, immaturity of the mechanisms involved in this process may permit reopening. Finally, in the presence of intermittent hypoxemia associated with the respiratory distress syndrome, the ductus arteriosus of the preterm infant may reopen. Recently Hammerman et al investigated the effects of prolonged indomethacin therapy (0.2 mg/kg/q 12 hours x 3 doses then 0.2 mg/kg/day x 5 days) on ductal closure.[35] They found that prolonged administration of indomethacin resulted in fewer recurrences of ductal opening and decreased need for surgical intervention.

If pharmacotherapy fails to close a patent ductus arteriosus, surgical ligation may be necessary. Wagner and coworkers concluded that surgical ligation is a safe and effective means of closing the patent ductus arteriosus in small premature infants.[36] Among the 268 operations in their study, one death was directly attributable to the surgical procedure, and short-term mortality was only 3%. Intraoperative complications were problems that may be expected to occur in premature infants (e.g., hypothermia, bradycardia, hypotension and ventilatory difficulties) during surgery. Despite the low rate of surgical morbidity and mortality after PDA ligation, some preterm neonates

have unstable postoperative courses for one to two days. Decrease in arterial oxygen saturation may occur following ductal closure because of temporary ventilation perfusion mismatching. To minimize this potential complication, administer a second or even third course of indomethacin before surgery. If facilities permit, surgical ligation within the neonatal unit may minimize complications associated with transport of these tiny infants to and from the operating room. Judicious use of vasopressors such as dopamine or dobutamine may be beneficial postoperatively to augment cardiac function.

Ductus arteriosus and congenital heart disease

The ductus arteriosus may play an important role in congenital heart lesions. The complications of cyanotic heart lesions, particularly those causing pulmonary outflow tract obstruction, may be ameliorated by the presence and persistence of a ductus arteriosus. In these lesions, blood flow to the lungs is dependent on ductal blood flow. Since closure of the ductus can result in clinical deterioration and a significant decrease in pulmonary blood flow, maintenance of ductal patency is often necessary until further interventional measures can be taken. Infants with coarctation or atresia of the aorta and hypoplastic left heart syndrome may have systemic arterial circulation supplied primarily from the pulmonary circulation through the ductus arteriosus. Closure of the ductus arteriosus may result in hypotension, decrease in blood flow to abdominal organs and the lower extremities, shock and/or death. Patency of the ductus arteriosus may be maintained with constant infusion of 0.025 to 0.10 mcg/kg/min prostaglandin E_1. We usually use an initial dose of 0.1 mcg/kg/min and, after ductal patency has persisted, gradually decrease the dose to limit potential side effects. Side effects of prostaglandin E_1 include apnea (12%, may be severe), fever (16%), rash (15%), central nervous system irritability (16%) and possibly increased incidence of infection.[37]

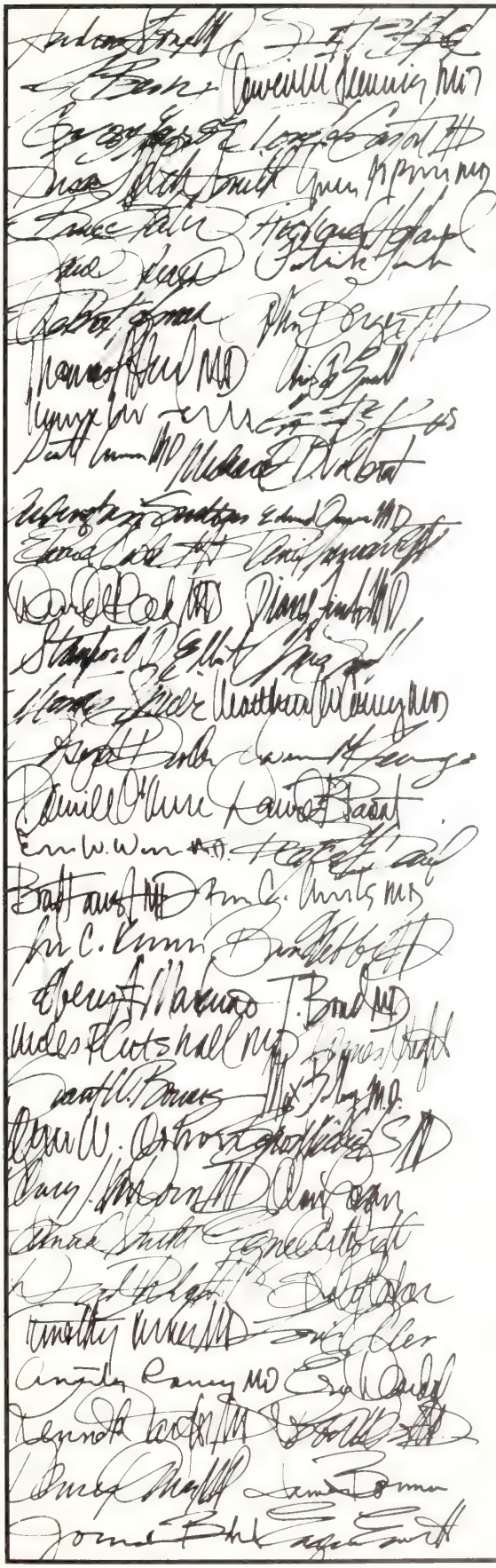
Summary

Patent ductus arteriosus is a relatively common complication of prematurity. Some infants may appear asymptomatic initially but then develop significant hemodynamic compromise and sequelae. Although some infants will improve with fluid restriction, diuretics, increased end distending pressures and time, others will require pharmacotherapy or surgery. Risks and benefits for each approach require individualization to the patient's needs and clinical status. Prompt recognition and treatment of a patent ductus arteriosus are necessary to minimize short-term and long-term morbidity. In addition, for those neonates with ductal dependent congenital heart lesions, maintaining ductus arteriosus patency with prostaglandin E_1 may be life-saving. ❑

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Proton beam therapy using the IU Cyclotron Facility

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Within the next few months, the Indiana University Cyclotron Facility in Bloomington will become the third radiation therapy treatment center in the United States to offer proton beam therapy. Initially, patients with tumors and vascular malformations of the brain and advanced head and neck tumors will be selected for treatment. Development of this proton therapy project required close cooperation between the Indianapolis and Bloomington campuses and is made possible through support grants from the Intercampus Research Fund, the Indianapolis Research Support Committee and the Biomedical Research Support Committee of Indiana University. In addition, a generous $300,000 support grant from the Indiana Lions Club Cancer Control Program provided the funds for developing a patient treatment facility at the Cyclotron.

High-energy proton beam therapy is not a new treatment modality and has been used to treat more than 12,000 patients worldwide. These treatments began 31 years ago at the Harvard facility,[1] which is now one of the 13 treatment centers in the world offering this unique form of therapy. Because of high construction costs and the unusually large numbers of highly trained individuals required to operate and maintain the sophisticated equipment, few patients in the United States are treated with this therapy. In addition, most proton facilities have been designed and built for basic nuclear physics research. An exception is the hospital-based proton accelerator in use in California at Loma Linda Medical Center.[2]

Advantages of proton therapy

Proton beam therapy has a significant advantage over conventional radiation therapy because proton beams often can treat tumors at anatomical sites that are difficult or impossible to treat using conventional therapy. This is primarily due to the higher concentration of dose in the tumor relative to the surrounding normal tissue.

Three major physical characteristics of proton beams are responsible for this advantage[3,4]:

1. Protons are heavy particles (1836 x mass of an electron) and have a positive charge of one.
2. Proton penetration in matter is finite and, accordingly, the dose immediately beyond the end of their penetration range is virtually zero.
3. The depth of penetration of protons into tissue is a function of their energy.

Proton beams deposit large amounts of energy just before their maximum depth of penetration, resulting in a highly localized dose known as the "Bragg Peak" *(Figure)*. By varying the energy of the beam, the Bragg Peak can be concentrated at any depth within the body. Thus, the clinical interest in proton therapy is based on the ability of the beam to deliver a precise uniform dose of radiation across the target tissue with a minimal dose being delivered to the surrounding normal tissue. By using single or multiple proton beams, smaller treatment volumes are produced for selected anatomical sites compared to x- and gamma ray therapy.

Proton beam therapy can be given as both fractionated and single-dose therapy. Single-dose proton therapy is planned in conjunction with the stereotactic programs of the Section of Neurological Surgery at the Indiana University Medical Center.

Clinical results of proton therapy

As of June 1991, a worldwide total of 11,763 patients have been treated with proton beams in 13 centers.[3] Approximately 46% of all patients treated with protons had benign intracranial lesions, i.e., pituitary adenoma and arteriovenous malformations. An additional 32% were treated for malignant tumors of the retina. Among the other categories, tu-

mors of the base of skull and cervical spine represent the two next most common sites of treatment. Because proton beam facilities were built primarily for research in physics laboratories, severe restrictions have been placed on treatment techniques; as a result, only a few anatomical areas involving tumors were considered for treatment.

These limitations included:

1. A horizontal treatment beam only. This is opposed to isocentric linear accelerators currently used in cancer centers. Isocentric linear accelerators permit 360° rotation of the treatment head, which allows tumors to be treated from any angle.
2. Limited energy of the proton beams. Some proton beam facilities have energies available that permit only the treatment of tumors lying close to the surface.
3. Restricted availability of treatment time. In most centers, the treatment beam is available for only a few days at a time, which severely restricts the number of treatments that can be given.

Despite these limitations, impressive results have appeared in the literature. Uveal melanoma, an uncommon malignancy, has been treated primarily at three centers, and the combined results have produced an impressive 96% actuarial local control with a control rate of 99% within the treated area. The few failures reported occurred along the margins of the treatment area or at distant sites within the globe.[5] The local control rates are among the highest reported in the literature for human tumors of one type occurring in one anatomical site treated by external beam radiation therapy. Visual outcome has been judged to be good, despite the exceptionally high doses of radiation used. Deaths in this series were principally the consequence of distant metastasis.

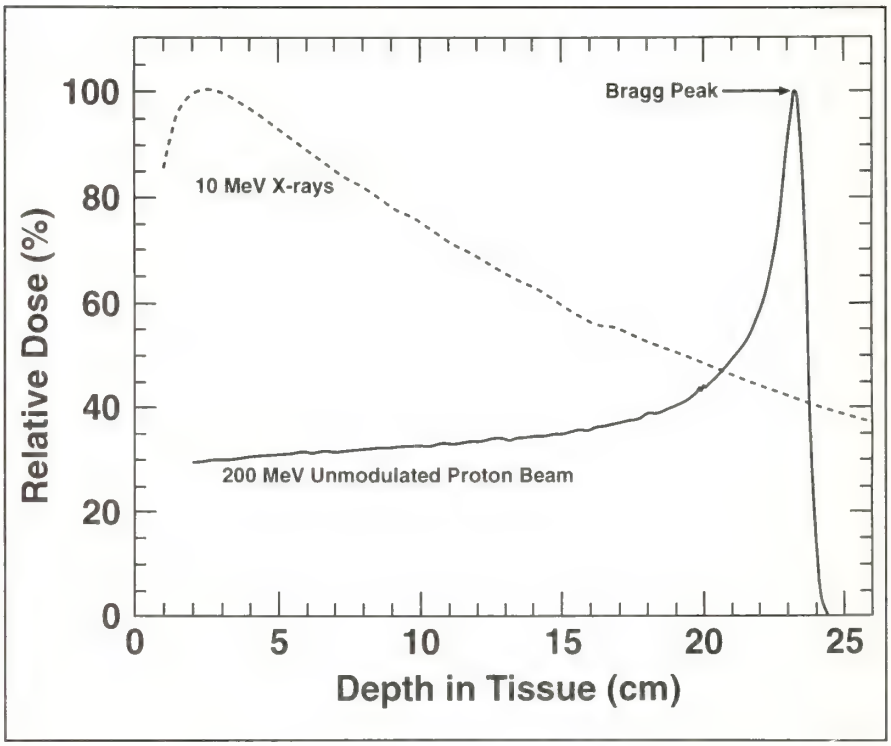


Figure: The central axis depth dose curve comparing a 200 MeV proton beam with a 10 MeV x-ray beam.

The other major category of tumors treated by proton beam techniques was the sarcomas of the skull base. These tumors present especially difficult treatment problems because of the complex and critical anatomy in that area. The immediately adjacent brain, brain stem, cranial nerves, blood vessels, eyes and middle ear make definitive surgical resection rarely feasible and limit the amount of radiation that can be given to this area. Using currently available radiation therapy (x- and gamma ray) techniques and doses (5000 cGy), local control rates of 36% at 3.5 years can be achieved.[6] Proton beam therapy has produced actuarial five-year local control rates in 215 patients (85 chondrosarcomas and 130 chordomas) of the skull base and cervical spine at 91% and 65%, respectively.[3]

Treatment of malignant tumors in other sites is under way with early results of tumor control either equal to or surpassing standard proton therapy.[3]

Proton Radiation Oncology Group

When the Indiana University Cy-

clotron is activated for proton beam therapy, Indiana University will become an active member of the Proton Radiation Oncology Group, which is sponsored by the U.S. National Cancer Institute and the American College of Radiology.

The Proton Radiation Oncology Group, formed in May 1991, is responsible for the following:

1. Stimulating interest in activating clinical trials in the different proton therapy centers in the United States and abroad.
2. Organizing and managing the proton therapy clinical trials.
3. Providing data management of patients treated with proton therapy.
4. Encouraging the prompt reporting of results from the trials.

The cooperation between the Bloomington campus and the IU Medical School in Indianapolis has allowed the Cyclotron to become a proton beam therapy facility in addition to a research facility. It will offer great potential therapeutic advantage to the residents of Indiana and the Midwest. Initial clinical trials began early in 1993, and the proton beam will be available for more extensive use at the end of 1993. ❑

Drs. Hornback, Sandison and Bloch are with the Indiana University School of Medicine, Department of Radiation Oncology, in Indianapolis. Dr. Cameron is with the IU Department of Physics, Cyclotron Facility, in Bloomington. Dr. Nelson is with the IU School of Medicine, Section of Neurological Surgery, in Indianapolis.

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References

1. Sisterson JM, Cascio E, Koehler AM, Johnson KN: Proton beam therapy: Reliability of the synchrocyclotron at the Harvard Cyclotron Laboratory. *Phys Med Biol*, 36(2):285-290, 1992.

2. Coutrakon G, et al: A prototype beam delivery system for the proton medical accelerator at Loma Linda. *Med Phys*, 18(6):1093-1099, 1991.

3. Suit H, Urie M: Proton beams in radiation therapy. *J Natl Cancer Inst*, 84:3, Feb. 5, 1992.

4. Suit HD, Goitein M: Rationale for use of charged particle and/or fast neutron beams in radiation therapy. In Meyn RE, Withers HR, eds. *Radiation Biology in Cancer Research*. New York, NY: Raven Press; 1980:547-565.

5. Wang CC: *Clinical Radiation Oncology*. Littleton, MA: Wright Publishers; 1988.

6. Austin-Seymour M, Munzenrider JE, Goitein M, et al: Progress in low LET heavy particle therapy: Intracranial and paracranial tumors and uveal melanomas. *Rad Res*, 8:S219-S226 (suppl), 1985.

drug names

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Dosage forms:	Capsules, powder for suspension	Tablets

	MIVACRON	MEVACOR
Category:	Muscle relaxant	Antihyperlipidemic
Brand name:	Mivacron, BW	Mevacor, MSD
Generic name:	Mivacurium chloride	Lovastatin
Dosage forms:	Injection	Tablets

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Such misunderstandings can result in the administration of a drug not intended by the prescriber. Awareness of such look-alike and sound-alike drug names can reduce potential errors. ❑



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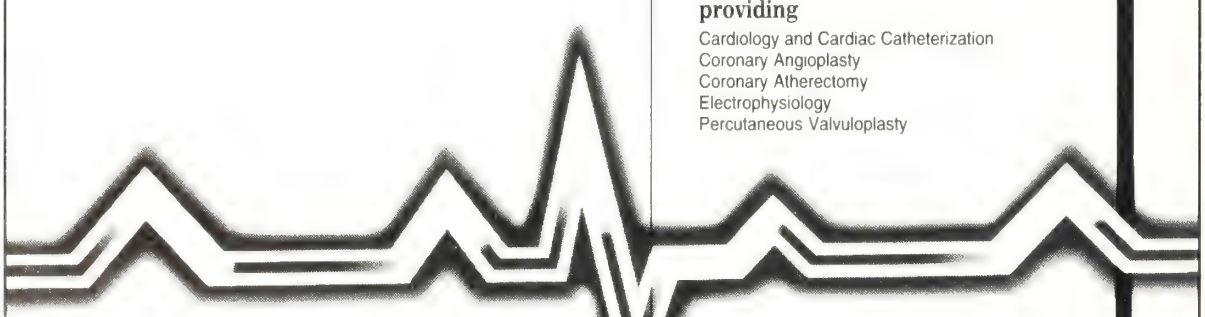
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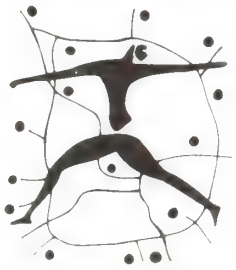
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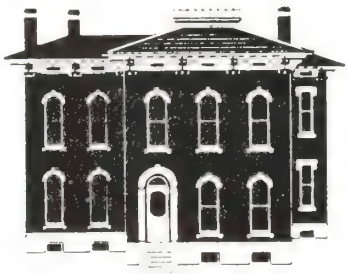
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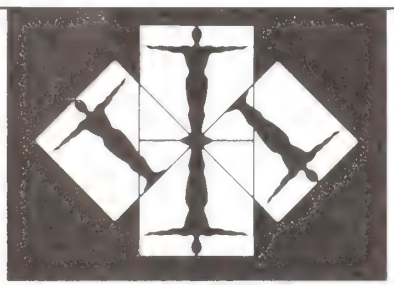
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about the artist

Paintings reveal pain of artist's childhood abuse

Tina Sims
Managing Editor

Artist Rush Cole was trembling with fear. It was only a few hours before the public had its first look at the paintings that revealed the torment of her abusive childhood, and she was not sure she was prepared to disclose her past or handle the reactions of viewers.

Her fears were unfounded. The exhibit moved people to tears and caused many to remember the abuse they had suffered. "It had touched a chord," says Cole.

One of her works, "For Karen II," is featured on the cover of this issue to highlight the article on family violence.

Since she first displayed her seven paintings on abuse in December 1992, the Indianapolis artist has realized how many other people are victims of abuse. People have expressed thanks to her for depicting so vividly the agony they too had experienced. Others have said, "Your paintings make me know I'm not crazy."

Admirers of her work include Marilyn Van Derbur, a former Miss America. During a visit to Indianapolis to speak on her experience as an abused child, Van Derbur saw Cole's paintings and was "really moved" by them, Cole says. Cole also learned how widespread abuse is when Van Derbur asked how many in the audience had been abused. Cole estimates that 80% of the 700 people in attendance raised their hands.

Ten years ago, Cole says she herself wouldn't have been able to look at the paintings because she had not yet fully understood what happened to her as a child. It was easier to suppress the memories than confront them.

That changed about a year ago when her daughter went to live with Cole's ex-husband, a move Cole approved of. (She thought her daughter should have the chance to get to know her father.) "When she left, I had the room, the space and the time to address what had happened to me," Cole says. "I had to let out the pain."

Releasing the pain took the form of the paintings that tell the story of her suffering. Until then, "I was terrified to paint anything that was in me from my childhood," she says.

Previously she painted portraits and landscapes – serene, pretty things, she says. "I realize now I was in denial."

By painting the seven works she calls the N.O.T.S. (Night of the Soul) series, Cole began to understand her fears. "The only way to release a fear is to walk through it," she says, and painting set her on the journey.

Since the first exhibit, Cole has displayed her paintings several times in conjunction with rallies advocating improved services and care for abused children.

Born in Vincennes 42 years ago, Cole grew up in northern Indiana and graduated from Crown Point High School. She says she, her four sisters and one brother were all abused by their parents. Years of physical and sexual abuse forced her to conclude that she was an "awful" person.

"It is an absolute death of the ego" to realize your parents can inflict such abuse, Cole says. The only time she received affection was after a particularly severe beating, when her mother would hug her and tell her she beat her only to demonstrate her love.

Cole's healing process has involved learning about abusers. She now realizes that most abusers were abused as children and that they, in turn, are more likely to abuse their children. Because her father was orphaned at birth and grew up in a series of Depression-era foster homes, she wonders if perhaps he was abused.

Although she does not see her parents because "they don't add anything good to my life," she believes her parents did love her but did not know how to express their feelings. She is beginning to forgive them – for her own benefit as part of recovery, not for her parents' benefit, she says.

The art titled "For Karen II" on the cover replaces the original "For Karen" that was part of the series of abuse paintings. When interested buyers wanted "For Karen" and Cole needed the income, selling the painting seemed like a good idea. Later, Cole regretted her decision. The owners refused Cole's offer to buy it back, however, so she repainted the work to fill the gap in her series.

"I don't envision ever selling any of them again," Cole says, "They tell my story."

The Karen in the painting is Cole's birth name. Because she came to hate the sound of her name, which she associated with her violent childhood, she officially changed her first name to Rush in 1984.

That change is one of many occurring as she heals. "I no longer hate my name Karen or the child I was. I did what I had to, to survive. I am integrating all the parts of me. I'm becoming more whole every day." ❑

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alliance report

New name, strategic plan signal changes for alliance

Sue Ellen Greenlee
ISMA Alliance President
Lucy Reed Foltyniak
ISMA Alliance Corresponding Secretary

The ISMA Auxiliary officially changed its name to the ISMA Alliance at its annual convention in April. As allies, we are ready to continue our work as partners with our physician spouses, ensuring quality health care for the citizens of Indiana.

The first "alliance" president, Sue Ellen Greenlee of Kendallville, was installed for the 1993-1994 year by the AMA Alliance field director for Indiana, Esther Jansing from Kentucky. Also installed on the executive board were the following: Darlene Haddawi, Bloomington, president-elect; Valerie Gates, Valparaiso, first vice president; Terry Wallace, Fort Wayne, north vice president; Susan Schneider, Indianapolis, central vice president; Patty Lackey, Evansville, south vice president; Cheryl Haslitt, Muncie, recording secretary; Anita Davis, Terre Haute, treasurer; Hulda Classen, Elkhart, finance secretary; and Trudy Urgena, Marion, immediate past president.

Mrs. Greenlee, a 1956 graduate of Shortridge High School in Indianapolis and a 1960 graduate of Indiana University, is a former school teacher. She now serves on the Kendallville Plan Commission and the Board of Zoning Appeals and is a region field director for family support of the Indiana National Guard. She and her husband, Joseph A. Greenlee Jr., M.D., a general surgeon who also serves as a brigadier/general in the Indiana Air National Guard, have six children. She has served the county alliance for many years, most recently as treasurer, and has been active in the state alliance for 10 years.



Sue Ellen Greenlee

People frequently ask what the medical alliance is. It is a group of physicians' spouses – men and women – who volunteer their time to make a difference in the health care and health care issues in their local communities. Alliance members provide support and foster unity among physician families. They promote health care legislation that protects the quality of health care for both patients and physicians. Serving as a resource of educational and leadership materials for each county, the alliance works to develop a positive public image for the physician, the medical family and the practice of medicine in Indiana.

The state organization is composed of county alliances, each governed by their own bylaws and leadership, and is a member of the American Medical Association Alliance.

Kaleidoscope of change

Kaleidoscopes are getting popular again, probably because they are so representative of change – continuing change – that reflects our society today.

Change is in the air – and we have turned the corner.

Change – a new president of the United States.

Change – with a new outlook.

Change – in health care – is on the horizon.

Change – in working as partners with the physicians of the ISMA. We must remember who we as allies are. We are not a free-standing, independent organization, but a part of the ISMA.

Alliance can be like a kaleidoscope – continually changing, sparkling and getting better. Change is a law of life, and those who look only to the past and present are certain to miss the future.

Changing times are challenging, uncertain and not easy. Yesterday is gone. Auxiliary is gone. Alliance is here. Our newly defined goals and plans can be achieved.

This year marks a clear beginning for a new time of change with our new name and strategic plan. Change, though inevitable and stressful, can stimulate personal growth and make us stronger, deeper and more understanding.

With constant and never-ending pressure to change and reform medicine, we face the role of working with and for physicians, a role that has never been more important. Keep the kaleidoscope turning. Don't stop thinking about tomorrow. ❑



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Indiana State Medical Association

from the museum

Oren Cooley
Indianapolis

Psychiatrists have debated the causes of dementia praecox, the term originally used to denote schizophrenia, since psychiatrists first described the disorder in the 1800s.

In 1896, German psychiatrist Emil Kraepelin (1855-1926) identified dementia praecox as a disorder that physicians could distinguish from other psychiatric conditions, including manic-depressive illness. He noted that the major symptoms of this disorder included hallucinations, delusions, incongruous emotions and progressive intellectual impairment.

Kraepelin selected the term "dementia praecox" to stress the early mental deterioration that followed the onset of the disorder. The term "dementia praecox," however, was originated by Austrian psychiatrist Benedict Augustin Morel (1809-1873) in 1860 to describe a mental and emotional deterioration that had its onset around the time of puberty.

Besides modifying the term dementia praecox, Kraepelin described three types of this disorder: the paranoid, the hebephrenic and the catatonic. He also postulated that this disorder invariably followed a deteriorating course and, subsequently, remained incurable.

After observing patients in a large mental hospital, Swiss psychiatrist Eugen Bleuler (1857-1939), however, noted that on occasion the illness spontaneously remitted. In *Dementia praecox, oder die Gruppe der Schizophrenien* (1911), he wrote, "This disease may come to a standstill at any stage, and many of its symptoms may clear up very much, or altogether, but if it progresses it leads to a dementia of definite character."

These observations prompted Bleuler to drop the inadequate term dementia praecox. Instead, he developed the term "schizophrenia" to express his view that the disorder consisted of a group of diseases and that the disorder split the person's ability to harmonize various psychic functions, such as thinking and feeling.

Although Kraepelin and Bleuler both theorized that the disorder was caused by organic changes in the brain, Bleuler maintained that schizophrenia was curable. When several initially promising developments did not conclusively identify an organic cause, many psychiatrists began to seek the disorder's origins in psychogenic causes, such as traumatic childhood experiences.

Austrian neurologist Sigmund Freud (1856-1939) contended that schizophrenia was not a disease that psychiatrists could appropriately treat by psychoanalysis. However, Swiss psychiatrist Carl Jung (1875-1961) thought psychoanalysis could help physicians understand the hallucinations, delusions and other symptoms of this disorder.

Jung theorized that the disorder's symptoms resulted from the activities of a complex whose dynamic force originated in the strong emotions associated with that force. As a result of his investigations, he postulated that the disorder's symptoms served a purpose and, therefore, that physicians could analyze and interpret the verbalizations of schizophrenic patients.

While psychiatrists continued their efforts either to discover an organic cause or to determine a psychological origin, German psychiatrist Franz Kallmann (1897-1966) carefully conducted a study that attempted to prove a genetic predisposition towards schizophrenia. In *The Genetics of Schizophrenia* (1938), he noted that, in those cases where schizophrenic patients had an identical twin, 86% of the other twins also had the disorder.

The subsequent studies by Dr. Kallmann and by other researchers, however, did not eliminate the possibility that organic or environmental factors could play a role. In the 1950s, French surgeon Henri Laborit (1914b) demonstrated to French psychiatrist Pierre Deniker (1917b) that certain antihistamines, especially chlorpromazine, could reduce the extreme agitation and withdrawal often exhibited by schizophrenic patients.

By the late 1960s, additional studies indicated that chlorpromazine and other antischizophrenic drugs reduce the excessive transmission of dopamine that occurs in the brains of schizophrenic patients. Although these drugs may reduce various symptoms, they do not eliminate the hallucinations, incongruous emotions and progressive intellectual impairment that Kraepelin first identified as the hallmarks of this disorder. ❑

Sources: *A History of Clinical Psychology* (1991) by John M. Reisman and *The Brain* (1984) by Richard M. Restak, M.D.

Oren Cooley is the director of the Indiana Medical History Museum in Indianapolis. For information, call (317) 635-7329.

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- Richard Davidson, American Hospital Association
- Steven Schroeder, M.D., The Robert Wood Johnson Foundation
- Uwe Reinhardt, Princeton University
- James Todd, M.D., American Medical Association
- Lynn Etheridge, formerly of Jackson Hole Group

Saturday, October 16, 1993
Agenda

10 a.m. to 1 p.m.	Issues & Answers on Health Reform Panel	
1 p.m. to 3 p.m.	IMPAC Luncheon, Reporter Sheilah Kast, Speaker	$15
3 p.m. to 5 p.m.	Health Reform Reaction Panel	
6 p.m. to 10 p.m.	President's Night	$50
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Space will be limited during some sessions so early registrations are recommended. Please complete this application form and return it with your check made payable to the Indiana State Medical Association, 322 Canal Walk, Indianapolis, IN 46202-3252.

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cme calendar

St. Mary's Medical Center

St. Mary's Medical Center in Evansville will sponsor these CME courses:

Sept. 9 – Annual Joseph E. Coleman Pediatric Seminar, Pediatric Intensive Care, St. Mary's Medical Center, Evansville.

Sept. 16 – Annual Cancer Seminar: B Lymphocyte Disorders, Tri-State Hematology-Oncology Consultants, Evansville.

Oct. 23 – Annual Family Medicine Seminar, Primary Care Orthopaedics, Evansville.

For more information, call (812) 479-4468.

Nasser, Smith & Pinkerton

Nasser, Smith & Pinkerton Cardiology in Indianapolis will present "Practice Management Seminar: The Business Side of Medicine" Wednesday, Aug. 25 at the Ritz Charles in Carmel, Ind.

The seminar will teach participants how to prepare for health care reform, understand how a quality patient satisfaction program improves your marketing effort and how to effectively manage personnel issues through performance reviews and job descriptions.

For more information, call Janet Macabee at (317) 871-6089.

Methodist Hospital

Methodist Hospital of Indiana in Indianapolis will sponsor these CME courses:

July 25-31 – Diabetes Mini Fellowship, Happy Hollow Camp for Children, Nashville, Ind.

Aug. 25-31 – ATLS, Methodist Hospital, Indianapolis.

Sept. 18 – Health Care for the Homeless, Indiana Government Center, Indianapolis.

Oct. 8 – Neurology in Primary Care Medicine.

Oct. 30 – Cardiology for the Clinician.

For details, call (317) 929-3733 or 1-800-847-3370.

Indiana University

The Indiana University School of Medicine will sponsor these courses:

July 21-22 – Personal Database Design and Usage, LRC Tutorial Lab, IU Medical Center, Indianapolis.

Sept. 7-8 – Current Issues in Perinatal Care, University Place Conference Center, Indianapolis.

Sept. 7-11 – Fourth Annual Comprehensive Transthoracic and Transabdominal Fine Needle Aspiration Biopsy Cytology, University Place Conference Center, Indianapolis.

Sept. 10 – Tri-State Craniofacial Conference, Omni North, Indianapolis.

Sept. 13 – High-Risk Infant and Neonatal Nutrition, University Place Conference Center, Indianapolis.

Sept. 24 – Clinical Laboratory Improvement Amendments: How to Play the Game with the New Rules, University Place Conference Center, Indianapolis.

Sept. 28 – Advances in Pediatric Surgery: A Course for Pediatricians and Family Practitioners, University Place Conference Center, Indianapolis.

Sept. 30 – Update on Management of HIV Infection, University Place Conference Center, Indianapolis.

Oct. 1 – Recent Advances in Epilepsy, University Place Conference Center, Indianapolis.

Oct. 1-2 – Family Practice Update in Cardiology: Emphasis on Office Practice, Krannert Institute of Cardiology, Indianapolis.

Oct. 2 – Glaucoma Update, University Place Conference Center, Indianapolis.

Oct. 9-10 – Third Annual Stuart A. Kleit Symposium, Omni North, Indianapolis.

Oct. 23-24 – Advanced Trauma Life Support, Wishard Hospital, Indianapolis.

Oct. 29-31 – International Symposium on Advances in Laparoscopy and Colonectomy, Westin Hotel, Indianapolis.

For more information, call (317) 274-8353. ❑

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Arnett physicians provide hospital support services at two nearby community hospitals, Home Hospital with 365 beds, and St. Elizabeth Hospital with 375 beds. Arnett has diversified into other healthcare fields, including Arnett Health Systems (an HMO) and the corporate affiliates of Arnett Medical Supply and Arnett Pharmacy.

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Benefits

Our Medical Staff members enjoy competitive salaries and a generous benefit package. During the first two years of employment, Arnett offers a guaranteed minimum salary with a production bonus. After two years of successful practice experience, shareholder status with a productivity incentive formula is available. An excellent profit-sharing and investment plan is also available.

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Lafayette, Indiana is a thriving, low-crime community located in a county of approximately 132,000 people. Purdue University, known for academic leadership in the areas of engineering, agriculture, humanities, and sciences, and for Big Ten Sports, is nearby. Money Magazine recently identified Lafayette as one of the top 14 cities in which to live in the U.S.A.

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Lafayette, Indiana

obituaries

John J. DeFries, M.D.
Dr. DeFries, 74, a retired New Paris family physician, died April 13, 1993, at Goshen General Hospital.

He was a 1943 graduate of the Indiana University School of Medicine and a veteran of World War II.

Dr. DeFries retired in 1980, after 33 years as a New Paris physician. He had served on the Elkhart County Board of Health for 20 years and as a deputy coroner for one term.

Everett W. Gaunt, M.D.
Dr. Gaunt, 77, a retired Alexandria family physician, died May 2, 1993, at Community Hospital in Anderson.

He was a 1942 graduate of the Indiana University School of Medicine.

Dr. Gaunt practiced medicine in Alexandria from 1944 to 1984. He was the Alexandria health officer from 1944 to 1970 and the Madison County health officer from 1970 to 1989. He served several terms on the Alexandria School Board.

Richard J. Karberg, M.D.
Dr. Karberg, 77, a Lafayette obstetrician and gynecologist, died May 8, 1993.

He was a 1940 graduate of Rush Medical College in Chicago and a U.S. Army veteran of World War II.

In 1966, Dr. Karberg helped found the Woman's Clinic in Lafayette, the first joint practice of women's medicine in Indiana. He was president of the Tippecanoe County Cancer Society.

Hamlin B. Lindsay, M.D.
Dr. Lindsay, 87, a retired Washington, Ind., surgeon, died April 10, 1993, at his daughter's home in Indianapolis.

He was a 1932 graduate of the Indiana University School of Medicine and an Army Medical Corps veteran of World War II.

Dr. Lindsay, who practiced medicine from 1935 to 1990, operated Washington Clinic. He was on the surgical staffs of Daviess County Hospital and Methodist Hospital in Indianapolis. He was a 55-year member of Kiwanis and received its Legion of Honor Award in 1992.

John B. Stetson, M.D.
Dr. Stetson, 66, professor emeritus at Rush-Presbyterian-St. Luke's Medical Center in Chicago, died April 15, 1993, at his home in Greencastle.

He was a 1951 graduate of Harvard Medical School and served in the Navy Reserve in World War II.

Dr. Stetson, an anesthesiologist, had taught at the Indiana University School of Medicine. He had been a member of the Putnam County Medical Society.

Maurice A. Turner, M.D.
Dr. Turner, 86, a retired Martinsville anesthesiologist and family physician, died April 28, 1993.

He was a 1946 graduate of the Indiana University School of Medicine.

Dr. Turner retired in the 1970s. He was a member of First United Methodist Church in Martinsville. ❑

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people



Dr. Beeson

Dr. William H. Beeson, an Indianapolis facial plastic surgeon, was elected to the board of directors of the Federated Ambulatory Surgery Association.

Dr. Larry Rink, a Bloomington internist, received a Sagamore of the Wabash Award from Gov. Evan Bayh. He has achieved worldwide recognition for his athletic cardiology research and was one of the physicians for U.S. athletes in the 1992 Olympic Games in Spain.

Dr. John R. Hayes, an Indianapolis psychiatrist and director of academic affairs at St. Vincent Hospital, has been admitted to the American College of Psychiatrists.

Dr. Deborah I. Allen, chairman of the department of family medicine at the Indiana University School of Medicine, was named Distinguished Alumna of the Year by the school's Alumni Association.

Dr. Barbara K. Siwy, an Indianapolis plastic surgeon, gave a presentation on "Cultured Epidermis: Indiana University Medical Center's Experience" at the American College of Surgeons annual meeting in San Juan, Puerto Rico. She discussed the silicone implant controversy on the "Focus on Health" program on a local Indianapolis cable television station.

Dr. Jay L. Grosfeld, Lafayette Page professor of surgery and chairman of the department of surgery at the Indiana University Medical Center, was selected president-elect of the American Pediatric Surgical Association.



Dr. Byrne

Dr. Frank D. Byrne, a Fort Wayne specialist in pulmonary disease, critical care and internal medicine, was elected medical staff president of Parkview Hospital in Fort Wayne. **Dr. Warren C. Hauck**, a gastroenterologist, is the president-elect, and **Dr. Richard A. Kelty**, a family practitioner, is the secretary-treasurer.

Dr. K. Donald Shelbourne, an orthopaedic surgeon with the Methodist Sports Medicine Center in Indianapolis, was the guest editor and contributing author for the first issue of a national medical journal titled *Operative Techniques in Sports Medicine*. Other orthopaedists with the Methodist

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

March
Alley, Thomas W., Indianapolis
Anigbo, Anthony A., Valparaiso
Crabb, Daniel G., Carmel
Drake, James R., Anderson
Dulay, Dion J., Evansville
Gilkison, William M., Indianapolis
Huus, John C., Evansville
Johnson, Phillip M., New Albany
Kamen, Jack M., Indianapolis
Nowzaradan, Philip, Valparaiso
Painchaud, Lionel A., Muncie
Perry, Guy F., Indianapolis
Rea, Robert A., Goshen
Vokes, Tamara P., Munster

April
Aeschliman, Dale H., Fort Wayne
Andrews, Ronald K., New Palestine
Aspy, Sandra L., Rushville
Ayers, Johnnie, Kokomo
Basavaraja, Hirematada, Muncie
Bathina, Radha R., Fort Wayne
Bleza, Maximo T., Munster
Bockelman, Henry W., Evansville
Cortese, Thomas A., Indianapolis
Das, Amal K., Kokomo
DeLa Cotera, Frederico G., Munster
Felker, Dean R., Greenfield
Gentile, Jonathan P., Fort Wayne
Goode, Roy L., Columbus
Harris, Garnet R., Danville
Hathaway, William H., Auburn
Huss, Richard G., Muncie
James, Charles E., Zionsville
Johns, Janet S., Lafayette
Kintanar, Thomas A., Fort Wayne
LaFollette, James W., Bloomington
Lawton, Dennis F., Muncie
Lewis, Merral B., Evansville
Marhenke, Jon D., Indianapolis
Mourtada, Raghid, Fort Wayne
Nicely, Polly G., Indianapolis
Patel, Narendrakumar M., Fort Wayne
Pyle, Susan K., Union City
Razek, Aly A., Evansville
Sadove, Alan M., Indianapolis
Salberg, Larry M., Merrillville
Sartore, Gilbert A., Evansville
Schafer, Scott W., Logansport
Schloss, Robert P., Fort Wayne
Stearley, John S., Gosport
Steiman, David L., Indianapolis
Stouder, Gary S., Greenfield
Voskuhl, William L., Charlestown
Wagner, Richard A., Evansville

Sports Medicine Center who contributed to the issue were **Dr. Thomas E. Klootwyk, Dr. Charles D. Van Meter** and **Dr. John R. McCarroll**.

Dr. Stephen W. Perkins, an Indianapolis facial plastic surgeon, was an instructor and panelist at the Sixth International Symposium of Facial Plastic Surgery in San Francisco. He was an instructor for courses on transconjunctival blepharoplasty and improved techniques in dermabrasion and participated in a panel discussion of blepharoplasty. He and **Dr. Ronald J. Caniglia** of Indianapolis presented a paper on "Micropigmentation for Eyelash Enhancement: A Realistic Evaluation of Permanent Eyeliner When Used as an Adjunct to a Facial Plastic Surgery Practice."

Dr. John H. Abrams, an Indianapolis ophthalmologist, spoke on "Sports Related Posterior Segment Eye Trauma" at the International Academy of Sports Vision meeting in Las Vegas and participated in a panel discussion of providers of eye care for collegiate and professional athletes. He was the ophthalmologist for the NCAA Midwest Regional basketball games and the Midwest Collegiate Conference basketball tournament, both held in Indianapolis.

Dr. Claude C. Reeck of Indianapolis was elected president of the Indiana Orthopaedic Society. Other officers are: **Dr. Alan J. Habansky**, Muncie, president-elect; **Dr. Marlin L. Troyer**, South Bend, past president; **Dr. Clyde B. Kernek**, Indianapolis, secretary/treasurer; **Dr. Edward L. Brundick**, Evansville, member-at-large; and **Dr. Bryant A. Bloss**, Evansville, chairman of the membership committee.

Three physicians with Nasser, Smith & Pinkerton Cardiology in Indianapolis recently gave presentations. **Dr. Lawrence E. Gering** spoke on "Treatment of Ischemic Heart Disease in the '90s" and **Dr. Timothy Story** spoke on "High Blood Pressure, Lipids, Arteries and the Future" at the Cardiovascular Update in Indianapolis. **Dr. Borys Surawicz** lectured at the Centennial Cardiology conference in Cleveland.

Dr. William A. Kammeyer, a Fort Wayne family physician, became qualified as a certified medical review officer.

Dr. Walter J. Daly, dean of the Indiana University School of Medicine, received the school's 1993 award from the Newcomen Society of the United States for contributions to the free enterprise system. He also was named master of the American College of Physicians.

Dr. Phillip T. Hodgin has retired after 46 years as an Orleans family physician.

Dr. Gregory Ellis, a pathologist, was elected chief of staff of St. John's Medical Center in Anderson. Other officers are: **Dr. John A. Moss**, an otolaryngologist, medical staff president; **Dr. Khali G. Wakim**, a surgeon, president-elect; and **Dr. John Woodall**, a family physician, secretary/treasurer.

Dr. Merritt O. Alcorn, a retired Madison pathologist, was among several health care professionals invited to Washington, D.C., to discuss proposals for health care reform.

Dr. Stephen R. Havens, a family physician, was named president of the medical staff at Clark Memorial Hospital in Jeffersonville. Other officers are: **Dr. Richard M. Spalding**, an internist, president-elect, and **Dr. William Sligar**, an orthopaedic surgeon, secretary/treasurer.

Dr. Polly Nicely, chief physician at the Indiana Women's Prison in Indianapolis, was named a trustee of the YMCA Foundation of Greater Indianapolis.

Dr. Charles Fisch, a cardiologist at the Indiana University Medical Center, received the Gifted Teacher Award from the American College of Cardiology.

Dr. D. Craig Brater of the Indiana University Medical Center received the Rawls-Palmer Progress in Medicine Award from the American Society for Clinical Pharmacology.

Dr. Robert H. Rumana has retired after 20 years as a nephrologist with Caylor-Nickel Clinic in Bluffton.

Dr. Arnold "Larry" Carter of Muncie has received the National Achievement Award from the National Multiple Sclerosis Society. The associate director of the Family Practice Center at Ball Memorial Hospital in Muncie, Dr. Carter was diagnosed with multiple sclerosis in 1973.

Dr. Donald W. Tharp, a Winchester ophthalmologist for the past 15 years, has retired.

Dr. Jaap Lind, a retired Lafayette orthopaedic surgeon, arranged for an injured soldier with the Croatian Defense Council in Bosnia to be brought to St. Elizabeth Hospital Medical Center in Lafayette for treatment. Dr. Lind is a member of the International Organization of Migration, which has been working with war victims in Bosnia.

Dr. Maurice John, a Jeffersonville ophthalmologist, presented two lectures on the excimer laser during a trip to Brazil, South America. He also performed free refractive and thera-

people

peutic surgery with the excimer laser.

Dr. Paul Howard, a cardiologist, was elected president of the medical staff at St. Joseph's Medical Center in South Bend. Other officers are **Dr. Brian Moloney**, a family physician, vice president, and **Dr. Mark Sandock**, an internist, secretary-treasurer.

Dr. Carl Griffin, a Lafayette emergency medicine specialist, passed the Medical Review Officer Certification Council examination.

Dr. Paul M. Dake, a Michigan City family physician, was named medical director for the new USS Family Medical Center in Merrillville, a clinic for employees of United States Steel Corp. and their families.

Dr. Carolyn N. Rawlins of Munster retired after 45 years as an obstetrician and gynecologist; she delivered more than 16,000 babies during her career.

Dr. Frank C. Donaldson, an Anderson obstetrician and gynecologist, retired after practicing more than 40 years; he delivered about 14,000 babies during his career.

Newly inducted fellows of the American Academy of Orthopaedic Surgeons include **Dr. Stephen B. Sexson** of Noblesville, **Dr. Jean M. Eelma** of Bloomington, **Dr. Salil Rajmaira** of Marion, **Dr. Barth T. Conard** of Lebanon and **Dr. Andrew T. Saltzman** of Evansville.

New ISMA members

Linda F. Abels, M.D., Indianapolis, internal medicine.

Vikramdev Appannagari, M.D., Valparaiso, anesthesiology.

David R. Bain, M.D., Brownsburg, family practice.

V. Paul Banning, M.D., Princeton, family practice.

Phillip H. Behrens, M.D., Evansville, cardiovascular diseases.

Carla M. Brandt, M.D., Evansville, neurology.

Anthony C. Breuer, M.D., Evansville, neurology.

David S. Brokaw, M.D., Indianapolis, orthopaedic surgery.

Paul J. Brownson, M.D., Indianapolis, family practice.

Johng H. Chun, M.D., Munster, anatomic/clinical pathology.

Luis E. Colon, M.D., Kokomo, ophthalmology.

Charles R. Crockett, M.D., Evansville, emergency medicine.

Arunava Das, M.D., Peru, orthopaedic surgery.

Bruce A. Davison, M.D., Columbus, pediatrics.

Amelita G. Del Mundo, M.D., Indianapolis, plastic surgery.

Raja Devanathan, M.D., Hobart, pulmonary diseases.

Karen T. Dicke, M.D., Zionsville, radiology.

P. Eva Fadul, M.D., Indianapolis, anesthesiology.

John F. Fitzgerald, M.D., Indianapolis, internal medicine.

Linda Fundenberger, M.D., Indianapolis, ophthalmology.

S. Campbell Gabrielsen, M.D., Greenfield, general surgery.

Steven A. Galat, M.D., Mishawaka, general surgery.

Patricia M. Gentile, M.D., Indianapolis, psychiatry.

Kevin D. Gerig, M.D., Mishawaka, general surgery.

Barry W. Gest, M.D., Evansville, family practice.

B. Anthony Graves, M.D., Indianapolis, internal medicine.

James A. Hawk, M.D., Covington, family practice.

Bruce E. Heslin, M.D., Indianapolis, anesthesiology.

Robert J. Huler, M.D., Indianapolis, orthopaedic surgery.

Louis F. Jameira, M.D., Evansville, cardiovascular diseases.

H. Clifton Knight Jr., M.D., Indianapolis, family practice.

Magnus E. Kolbeinsson, M.D., Indianapolis, general surgery.

Emmanuel Kratsios, M.D., Indianapolis, family practice.

Robert M. Lombard, M.D., Evansville, pulmonary diseases.

S. Chace Lottich, M.D., Indianapolis, general surgery.

Elmer P. Mannlo, M.D., Indianapolis, cardiovascular diseases.

Karen G. Meighen, M.D., Indianapolis, child psychiatry.

Raymond V. Meldahl, M.D., Indianapolis, cardiovascular diseases.

Julio A. Morera, M.D., Evansville, pediatrics, cardiology.

Michael J. Need, M.D., Indianapolis, anesthesiology.

Hemendra S. Parikh, M.D., Merrillville, pediatrics.

Robert B. Parker, M.D., Evansville, cardiovascular diseases.

Christina L. Pinkerton, M.D., Indianapolis, family practice.

Nicholas M. Priscu, M.D., Indianapolis, internal medicine.

John C. Roberts, D.O., Washington, obstetrics and gynecology.

Alok K. Sarda, M.D., Kokomo, psychiatry.

L.R. Scherer III, M.D., Indianapolis, pediatric surgery.

Veena Shah, M.D., Munster, emergency medicine.

Fred A. Simon Jr., M.D., Goshen, obstetrics and gynecology.

Thomas D. Smith, M.D., New Haven, family practice.

Gregory W. Somerville, M.D.,

Fort Wayne, anesthesiology.

Rajiv Sood, M.D., Indianapolis, plastic surgery.

Vijayalakshmi Sripathy, M.D., Merrillville, family practice.

Uzi Talit, M.D., Evansville, cardiovascular diseases.

Vernon Taylor, M.D., Evansville, emergency medicine.

Thomas T. Tigges, M.D., Indianapolis, general surgery.

Vivien O. Tucker, M.D., Newburgh, family practice.

Jane Ann Werth, M.D., South Bend, obstetrics and gynecology.

William A. Zato, D.O., Crown Point, general practice.

Residents

James A. Balko, M.D., Indianapolis, anatomic/clinical pathology.

Joel C. Hamond, M.D., Indianapolis, general surgery.

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Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol* 1991;14:146-151

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Hypersensitivity to any component of this medication

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS)

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY, Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS, Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin, the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin.* See WARNINGS, Skeletal Muscle.

Antipyrine. Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol. Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION, Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*, a forward mutation assay in L5178Y TK +/− mouse lymphoma cells, a chromosomal aberration test in hamster cells, and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter²). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS, **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated, adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug.

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma, anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS, **Skeletal Muscle** and PRECAUTIONS, **Drug Interactions**.)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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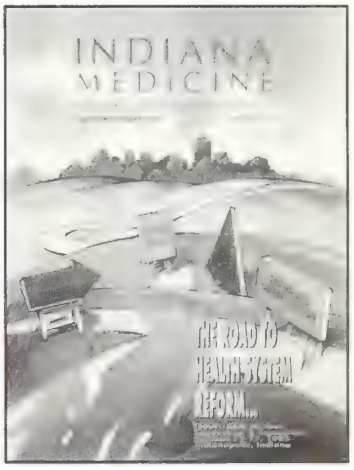
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This issue of INDIANA MEDICINE *is dedicated in memory of Frank B. Ramsey, M.D., editor emeritus, who died July 31. An obituary and tributes appear on pages 452 and 453.*

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

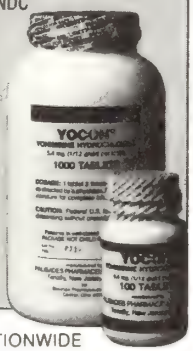
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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stethoscope

Budget bill repeals Medicare new physician fee disparity

The 1993 budget reconciliation bill, passed by Congress in August, repealed the Medicare new physician fee disparity and will allow separate reimbursement for interpreting electrocardiograms (EKGs). Physicians in their first four years of practice, formerly reimbursed at lower rates than their colleagues, will be brought up to par Jan. 1, 1994. To pay for separate reimbursement of EKGs, all physicians will receive about 73 cents less for office evaluation and management services and about $1.11 less for hospital visits. The reimbursement for interpretation should offset those cuts.

1994 ISMA dues statements to be mailed in October

All actively practicing physicians will receive their 1994 ISMA dues statements in October. There will be no increase in the 1994 ISMA dues.

The statement will reflect the dues for the state, county and district societies and the AMA. Optional contributions may be made to the Indiana Medical Political Action Committee and the Indiana Medical History Museum. The ISMA dues will remain at $385; however, the AMA dues will reflect a $20 increase, as approved by the AMA House of Delegates in June. The new AMA membership dues for full practicing physicians will be $420. The first-year and second-year practice rates also will reflect an increase. Resident and student rates will be the same. If you have dues questions, call Debbie Pierle at the ISMA, (317) 261-2060 or 1-800-257-4762.

AMA issues guidelines for physicians asked to self-query data bank

Because physicians have been subject to increasing pressure to self-query and disclose their National Practitioner Data Bank reports to unauthorized entities, the AMA has developed a sample letter for physicians to use to protect confidentiality.

The AMA also recommends that physicians request the following written documentation when entities such as preferred provider organizations, managed care plans or medical liability insurers ask for data bank information:

- That the requirement that the physician self-query the data bank and disclose the information to the entity is in compliance with the intent and statutory protections of the Health Care Quality Improvement Act;
- That the information disclosed to the entity will be protected from further disclosure under the relevant state peer review immunity statute(s);
- That the information will be used only for and maintained only for those purposes, such as quality assurance activities, that are protected under the relevant state peer review immunity statute(s); and
- That the entity will protect the confidentiality of the information to the fullest extent permitted by both state law and the Health Care Quality Improvement Act.

For a copy of the sample AMA letter, call Toni Settle at the ISMA. ❑

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letter to editor

At the risk of sounding pretentious, our group of pediatricians wishes to share with you some recent changes we have made that impact the immunization of children and Medicaid. Because of the recent significant decrease in the cost of the DPT vaccine, these savings are being passed on to our patients. With the approval of Tetramune DPT-HIB combined vaccine, the costs to our patients have once again fallen markedly.

Obviously, Medicaid is pleased with the savings, but more importantly, when we as physicians make immunizations more affordable and thereby more accessible, our children benefit.

The Committee on Infectious Diseases of the American Academy of Pediatrics and the Immunization Practices Advisory Committee both advocate the complete immunization of all children by 2 years of age. Indiana hopes to achieve a 90% age-appropriate immunization rate in 2-year-olds by 2000. This is not a burden that can be borne solely by the Indiana Department of Health. It will take all of us doing what we can to overcome missed immunization opportunities and barriers to vaccination to make this goal a reality. We hope all physicians in Indiana continue to consider the parts they can play. ❑

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editorial

All ISMA members invited to attend health reform forum

William H. Beeson, M.D.
ISMA President

The letter arrived at the Indiana State Medical Association headquarters handwritten on lined notebook paper: "I am in need of a doctor for my husband, three children and myself. My problem is that I don't have any medical insurance, and I cannot afford health care."

As practicing physicians, we are approached often by people with a similar dilemma over access to medical care. Indeed, access to care and increasing medical costs are the catalysts that prompted the health care debate now underway.

Still unclear is exactly how this woman and millions of other Americans will receive care under a revamped health care system of theories that are largely untested. For physicians, the questions remain: Will I be able to provide quality care in a system that emphasizes cost containment? Will patients have the freedom to choose their own physicians? Will physicians be free to determine the practice arrangement they prefer?

The ISMA hopes to shed some light on those and other questions about national health system reform when the ISMA Annual Meeting convenes Oct. 15-17 in Indianapolis. During the convention, the ISMA will unveil its own health system reform proposal for consideration by the House of Delegates, which meets Friday, Oct. 15. On Saturday, Oct. 16, the ISMA has invited both state and national health care planners and strategists to present a panel discussion titled "The Road to Health System Reform."

The panel will begin at 10 a.m. and will provide commentary from Lynn Etheredge, one of the architects of managed competition, the concept expected to be contained in the Clinton health proposal. Etheredge is an independent consultant who served in the federal Office of Management & Budget during four administrations, working on Medicare, Medicaid and national health insurance in the 1970s.

He'll be joined by James Todd, M.D., executive vice president of the AMA. Dr. Todd will compare and contrast the Clinton proposal to the AMA's Health Access America plan.

Also participating will be Myra Selby, director of health care policy for the state of Indiana, and David Weinschrott, a research fellow at Hudson Institute in Indianapolis and author of a report titled "The Curable Crisis: Rethinking America's Health Care Priorities."

Others invited include Uwe Reinhardt, Princeton professor and member of the Physician Payment Review Commission, and Howard Dean, M.D., governor of Vermont and chairman of the Health Subcommittee of the National Governor's Association.

From the local front, Ian Rolland, chairman of Lincoln National Corp. and the Health Insurance Association of America, also has been invited to participate.

Following opening statements, the panelists will take questions from the audience. In addition to all ISMA members, we have invited representatives from state government, including Indiana's legislators, and representatives from labor, business and seniors groups.

While we discuss the impact of health system reform on practicing physicians, we can't overlook how it will affect our patients. A reactor panel of representatives of various consumer groups will meet from 3 p.m. to 5 p.m. Saturday to respond to comments made during the morning session. They will be joined by representatives of the ISMA.

This is the first time in many years that the ISMA has hosted forums such as these. An understanding of what may evolve in our health care system is critical to decisions that doctors practicing in Indiana will make. It is also critical to the wife and mother who is seeking medical care for her uninsured family. Whether you are a convention delegate or not, I invite you to be present and participate in this important activity. ❑

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VASERETIC® 10-25 *Next*
Enalapril Maleate-Hydrochlorothiazide

Dosage must be individualized; the fixed combination is not for initial therapy.

Evaluation of the hypertensive patient should always include assessment of renal function.

For a Brief Summary of Prescribing Information, see adjacent pages.

TABLETS
VASERETIC®
(ENALAPRIL MALEATE-HYDROCHLOROTHIAZIDE)

USE IN PREGNANCY: When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC® (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, *Fetal/Neonatal Morbidity and Mortality*



CONTRAINDICATIONS: VASERETIC is contraindicated in patients who are hypersensitive to any component of this product and in patients with a history of angioedema related to previous treatment with an angiotensin converting enzyme inhibitor. Because of the hydrochlorothiazide component, this product is contraindicated in patients with anuria or hypersensitivity to other sulfonamide-derived drugs.

WARNINGS: *General, Enalapril Maleate; Hypotension:* Excessive hypotension was rarely seen in uncomplicated hypertensive patients but is a possible consequence of enalapril use in severely salt/volume depleted persons such as those treated vigorously with diuretics or patients on dialysis.

Syncope has been reported in 1.3 percent of patients receiving VASERETIC. In patients receiving enalapril alone, the incidence of syncope is 0.5 percent. The overall incidence of syncope may be reduced by proper titration of the individual components. (See PRECAUTIONS, *Drug Interactions*, and ADVERSE REACTIONS.)

In patients with severe congestive heart failure, with or without associated renal insufficiency, excessive hypotension has been observed and may be associated with oliguria and/or progressive azotemia, and rarely with acute renal failure and/or death. Because of the potential fall in blood pressure in these patients, therapy should be started under very close medical supervision. Such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart or cerebrovascular disease, in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given without difficulty once the blood pressure has increased after volume expansion.

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis and/or larynx has been reported in patients treated with angiotensin converting enzyme inhibitors, including enalapril. In such cases VASERETIC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis or larynx, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided.** (See ADVERSE REACTIONS.)

Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see also CONTRAINDICATIONS).

Neutropenia/Agranulocytosis: Another angiotensin converting enzyme inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Lithium generally should not be given with thiazides (see PRECAUTIONS, *Drug Interactions, Enalapril Maleate and Hydrochlorothiazide*).

Pregnancy, Enalapril-Hydrochlorothiazide: There was no teratogenicity in rats given up to 90 mg/kg/day of enalapril (150 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose) or in mice given up to 30 mg/kg/day of enalapril (50 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose). At these doses, fetotoxicity expressed as a decrease in average fetal weight occurred in both species. No fetotoxicity occurred at lower doses, 30/10 mg/kg/day of enalapril-hydrochlorothiazide in rats and 10/10 mg/kg/day of enalapril-hydrochlorothiazide in mice.

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC should be discontinued as soon as possible. (See *Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality*, below.)

Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality: ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of VASERETIC as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, VASERETIC should be discontinued unless it is considered lifesaving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Enalapril, which crosses the placenta, has been removed from neonatal circulation by peritoneal dialysis with some clinical benefit, and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

No teratogenic effects of enalapril were seen in studies of pregnant rats, and rabbits. On a mg/kg basis, the doses used were up to 333 times (in rats), and 50 times (in rabbits) the maximum recommended human dose.

Hydrochlorothiazide; Teratogenic Effects: Reproduction studies in the rabbit, the mouse and the rat at doses up to 100 mg/kg/day (50 times the human dose) showed no evidence of external abnormalities of the fetus due to hydrochlorothiazide. Hydrochlorothiazide given in a two-litter study in rats at doses of 4 - 5.6 mg/kg/day (approximately 1 - 2 times the usual daily human dose) did not impair fertility or produce birth abnormalities in the offspring. Thiazides cross the placental barrier and appear in cord blood.

Nonteratogenic Effects: These may include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

PRECAUTIONS: *General, Enalapril Maleate, Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe congestive heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with angiotensin converting enzyme inhibitors, including enalapril, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20 percent of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent pre-existing renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when enalapril has been given concomitantly with a diuretic. This is more likely to occur in patients with pre-existing renal impairment. Dosage reduction of enalapril and/or discontinuation of the diuretic may be required.

Evaluation of the hypertensive patient should always include assessment of renal function.

Hemodialysis Patients: Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes (e.g., AN 69®) and treated concomitantly with an ACE inhibitor. In these patients consideration should be given to using a different type of dialysis membrane or a different class of antihypertensive agent.

Hyperkalemia: Elevated serum potassium (greater than 5.7 mEq/L) was observed in approximately one percent of hypertensive patients in clinical trials treated with enalapril alone. In most cases these were isolated values which resolved despite continued therapy, although hyperkalemia was a cause of discontinuation of therapy in 0.28 percent of hypertensive patients. Hyperkalemia was less frequent (approximately 0.1 percent) in patients treated with enalapril plus hydrochlorothiazide. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with enalapril. (See *Drug Interactions.*)

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Warning signs or symptoms of fluid and electrolyte imbalance, irrespective of cause, include dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, confusion, seizures, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or after prolonged therapy. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia may cause cardiac arrhythmia and may also sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Because enalapril reduces the production of aldosterone, concomitant therapy with enalapril attenuates the diuretic-induced potassium loss (see *Drug Interactions, Agents Increasing Serum Potassium*).

Although any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease), chloride replacement may be required in the treatment of metabolic alkalosis.

Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

In diabetic patients dosage adjustments of insulin or oral hypoglycemic agents may be required. Hyperglycemia may occur with thiazide diuretics. Thus latent diabetes mellitus may become manifest during thiazide therapy.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

If progressive renal impairment becomes evident consider withholding or discontinuing diuretic therapy.

Thiazides have been shown to increase the urinary excretion of magnesium; this may result in hypomagnesemia.

Thiazides may decrease urinary calcium excretion. Thiazides may cause intermittent and slight elevation of serum calcium in the absence of known disorders of calcium metabolism. Marked hypercalcemia may be evidence of hidden hyperparathyroidism. Thiazides should be discontinued before carrying out tests for parathyroid function.

Increases in cholesterol and triglyceride levels may be associated with thiazide diuretic therapy.

Information for Patients; Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

Pregnancy: Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

NOTE: As with many other drugs, certain advice to patients being treated with VASERETIC is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions, Enalapril Maleate; Hypotension—Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS.)

Agents Causing Renin Release: The antihypertensive effect of enalapril is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: Enalapril has been used concomitantly with beta adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine and prazosin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: Enalapril attenuates diuretic-induced potassium loss. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia they should be used with caution and with frequent monitoring of serum potassium.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant enalapril and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Hydrochlorothiazide: When administered concurrently the following drugs may interact with thiazide diuretics:

Alcohol, barbiturates, or narcotics—potentiation of orthostatic hypotension may occur.

Antidiabetic drugs (oral agents and insulin)—dosage adjustment of the antidiabetic drug may be required.

Other antihypertensive drugs—additive effect or potentiation.

Cholestyramine and colestipol resins—Cholestyramine and colestipol resins bind the hydrochlorothiazide and reduce its absorption from the gastrointestinal tract by up to 85 and 43 percent, respectively. Thiazides may be administered two to four hours before the resin when the two drugs are used concomitantly.

Corticosteroids, ACTH—intensified electrolyte depletion, particularly hypokalemia.

Pressor amines (e.g., norepinephrine)—possible decreased response to pressor amines but not sufficient to preclude their use.

Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarine)—possible increased responsiveness to the muscle relaxant.

Lithium—should not generally be given with diuretics. Diuretic agents reduce the renal clearance of lithium and add a high risk of lithium toxicity. Refer to the package insert for lithium preparations before use of such preparations with VASERETIC.

Non-steroidal Anti-inflammatory Drugs—In some patients, the administration of a non-steroidal anti-inflammatory agent can reduce the diuretic, natriuretic, and antihypertensive effects of loop, potassium-sparing and thiazide diuretics. Therefore, when VASERETIC and non-steroidal anti-inflammatory agents are used concomitantly, the patient should be observed closely to determine if the desired effect of the diuretic is obtained.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Enalapril in combination with hydrochlorothiazide was not mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril-hydrochlorothiazide did not produce DNA single strand breaks in an *in vitro* alkaline elution assay in rat hepatocytes or chromosomal aberrations in an *in vivo* mouse

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bone marrow assay.

Enalapril Maleate: There was no evidence of a tumorigenic effect when enalapril was administered for 106 weeks to rats at doses up to 90 mg/kg/day (150 times* the maximum daily human dose). Enalapril has also been administered for 94 weeks to male and female mice at doses up to 90 and 180 mg/kg/day, respectively, (150 and 300 times* the maximum daily dose for humans) and showed no evidence of carcinogenicity.

Neither enalapril maleate nor the active diacid was mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril was also negative in the following genotoxicity studies: rec-assay, reverse mutation assay with *E. coli*, sister chromatid exchange with cultured mammalian cells, and the micronucleus test with mice, as well as in an *in vivo* cytogenic study using mouse bone marrow.

There were no adverse effects on reproductive performance in male and female rats treated with 10 to 90 mg/kg/day of enalapril.

Hydrochlorothiazide: Two-year feeding studies in mice and rats conducted under the auspices of the National Toxicology Program (NTP) uncovered no evidence of a carcinogenic potential of hydrochlorothiazide in female mice (at doses of up to approximately 600 mg/kg/day) or in male and female rats (at doses of up to approximately 100 mg/kg/day). The NTP, however, found equivocal evidence for hepatocarcinogenicity in male mice.

Hydrochlorothiazide was not genotoxic *in vitro* in the Ames mutagenicity assay of *Salmonella typhimurium* strains TA 98, TA 100, TA 1535, TA 1537, and TA 1538 and in the Chinese Hamster Ovary (CHO) test for chromosomal aberrations, or *in vivo* in assays using mouse germinal cell chromosomes, Chinese hamster bone marrow chromosomes, and the *Drosophila* sex-linked recessive lethal trait gene. Positive test results were obtained only in the *in vitro* CHO Sister Chromatid Exchange (clastogenicity) and in the Mouse Lymphoma Cell (mutagenicity) assays, using concentrations of hydrochlorothiazide from 43 to 1300 µg/mL, and in the *Aspergillus nidulans* non-disjunction assay at an unspecified concentration.

Hydrochlorothiazide had no adverse effects on the fertility of mice and rats of either sex in studies wherein these species were exposed, via their diet, to doses of up to 100 and 4 mg/kg, respectively, prior to conception and throughout gestation.

Pregnancy, Pregnancy Categories C (first trimester) *and D* (second and third trimesters). See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality*.

Nursing Mothers. Enalapril and enalaprilat are detected in human milk in trace amounts. Thiazides do appear in human milk. Because of the potential for serious reactions in nursing infants from either drug, a decision should be made whether to discontinue nursing or to discontinue VASERETIC, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: VASERETIC has been evaluated for safety in more than 1500 patients, including over 300 patients treated for one year or more. In clinical trials with VASERETIC no adverse experiences peculiar to this combination drug have been observed. Adverse experiences that have occurred, have been limited to those that have been previously reported with enalapril or hydrochlorothiazide.

The most frequent clinical adverse experiences in controlled trials were: dizziness (8.6 percent), headache (5.5 percent), fatigue (3.9 percent) and cough (3.5 percent). Adverse experiences occurring in greater than two percent of patients treated with VASERETIC in controlled clinical trials were: muscle cramps (2.7 percent), nausea (2.5 percent), asthenia (2.4 percent), orthostatic effects (2.3 percent), impotence (2.2 percent), and diarrhea (2.1 percent).

Clinical adverse experiences occurring in 0.5 to 2.0 percent of patients in controlled trials included: *Body As A Whole:* Syncope, chest pain, abdominal pain, *Cardiovascular:* Orthostatic hypotension, palpitation, tachycardia; *Digestive:* Vomiting, dyspepsia, constipation, flatulence, dry mouth, *Nervous/Psychiatric:* Insomnia, nervousness, paresthesia, somnolence, vertigo; *Skin:* Pruritus, rash, *Other:* Dyspnea, gout, back pain, arthralgia, diaphoresis, decreased libido, tinnitus, urinary tract infection.

Angioedema: Angioedema has been reported in patients receiving VASERETIC (0.6 percent). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis and/or larynx occurs, treatment with VASERETIC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In clinical trials, adverse effects relating to hypotension occurred as follows: hypotension (0.9 percent), orthostatic hypotension (1.5 percent), other orthostatic effects (2.3 percent). In addition syncope occurred in 1.3 percent of patients. (See WARNINGS.)

Cough. See PRECAUTIONS, *Cough*.

Clinical Laboratory Test Findings; Serum Electrolytes. See PRECAUTIONS.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.6 percent of patients with essential hypertension treated with VASERETIC. More marked increases have been reported in other enalapril experience. Increases are more likely to occur in patients with renal artery stenosis. (See PRECAUTIONS.)

Serum Uric Acid, Glucose, Magnesium, and Calcium: See PRECAUTIONS.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g percent and 1.0 vol percent, respectively) occur frequently in hypertensive patients treated with VASERETIC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1 percent of patients discontinued therapy due to anemia.

Liver Function Tests: Rarely, elevations of liver enzymes and/or serum bilirubin have occurred.

Other adverse reactions that have been reported with the individual components are listed below and, within each category, are in order of decreasing severity.

Enalapril Maleate—Enalapril has been evaluated for safety in more than 10,000 patients. In clinical trials adverse reactions which occurred with enalapril were also seen with VASERETIC. However, since enalapril has been marketed, the following adverse reactions have been reported: *Body As A Whole:* Anaphylactoid reactions (see PRECAUTIONS, *Hemodialysis Patients*); *Cardiovascular:* Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances including atrial tachycardia and bradycardia; atrial fibrillation; hypotension; angina pectoris; *Digestive:* Ileus, pancreatitis, hepatic failure, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, anorexia, glossitis, stomatitis, dry mouth; *Hematologic:* Rare cases of neutropenia, thrombocytopenia and bone marrow depression, a few cases of hemolysis in patients with G-6-PD deficiency have been reported in which a causal relationship to enalapril cannot be excluded; *Nervous System/Psychiatric:* Depression, confusion, ataxia, peripheral neuropathy (e.g., paresthesia, dysesthesia); *Urogenital:* Renal failure, oliguria, renal dysfunction (see PRECAUTIONS), flank pain, gynecomastia; *Respiratory:* Pulmonary infiltrates, bronchospasm, pneumonia, bronchitis, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection; *Skin:* Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, alopecia, flushing, photosensitivity; *Special Senses:* Blurred vision, taste alteration, anosmia, conjunctivitis, dry eyes, tearing.

Miscellaneous: A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash and other dermatologic manifestations.

Fetal/Neonatal Morbidity and Mortality: See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality*.

Hydrochlorothiazide—Body as a Whole: Weakness; *Digestive:* Pancreatitis, jaundice (intrahepatic cholestatic jaundice), sialadenitis, cramping, gastric irritation, anorexia; *Hematologic:* Aplastic anemia, agranulocytosis, leukopenia, hemolytic anemia, thrombocytopenia; *Hypersensitivity:* Purpura, photosensitivity, urticaria, necrotizing angiitis (vasculitis and cutaneous vasculitis), fever, respiratory distress including pneumonitis and pulmonary edema, anaphylactic reactions; *Musculoskeletal:* Muscle spasm; *Nervous System/Psychiatric:* Restlessness; *Renal:* Renal failure, renal dysfunction, interstitial nephritis (see WARNINGS); *Skin:* Erythema multiforme including Stevens-Johnson syndrome, exfoliative dermatitis including toxic epidermal necrolysis, alopecia; *Special Senses:* Transient blurred vision, xanthopsia.

* Based on patient weight of 50 kg.

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editorial

The positive side of health care spending

Adele Lash
ISMA Communications Director

The Clinton health reform proposal is expected to be released in mid-September. As the suspense builds about just what the proposal will include, the medical profession and the public read or hear daily rehashes of "the facts" about health reform and why we need it. Even now, "the facts" are only beginning to seep into the public conscience, while those in the medical profession have heard them for several years.

Every news article or editorial commentary lists the reasons we need reform: 37 million uninsured Americans and inflating health care costs, from 9% of the gross national product in 1980 to an anticipated 14% this year. With each article, we read why costs have risen so dramatically: inflation; the aging population; technology; professional liability; defensive medicine; lifestyles; violence; administrative red tape; and greed. The list appears in every story followed closely by the proposed panaceas: managed competition; managed care; global budgets; price controls; insurance reform; the single payer system; mandated benefits; health IRAs, etc.

Finally, some journalists are talking to experts who are turning the story around and saying, "Wait, health care in this country is big business. Let's look at what it adds to our economy." In a recent *Business Week* magazine, Economics Editor Christopher Farrell says that amidst all the rhetoric of cost containment, global budgets and greedy drug companies "is the fact that rising health care spending is not quite the devil it's made out to be."

No one can deny that increased spending has improved the quality of life and created economic growth, says Farrell. One could argue that health care is one of the few industries that has grown during the recession of the last few years.

Let's face it – health care employs nearly 10 million workers. Farrell says during the current economic recovery the health care industry has generated 512,000 new jobs. He further points out that nationally 44% of job gains for women and 53% for blacks were attributed to the health care field between 1987 and 1992.

When one considers the quality of life, one can't deny that Americans are living longer, thanks in part to new technological developments that are also part of our system. Medical research in the United States accounts for half of all research done in the world. The biotech industry's sales are expected to rise to $50 billion by the turn of the century, up from $6 billion, according to *Business Week*. What proposed cost containment measures do to this side of the health system is anybody's guess.

There's also an argument now gaining attention that our health care cost crisis would not be as extreme if productivity levels had maintained the rate they achieved before 1973. Since then, annual productivity has increased at about 1% annually. Previously, the annual growth rate was 2.5%.

The argument that we can no longer afford to spend so much of our gross domestic product for health care would not be valid if productivity and, therefore, incomes, had kept pace at pre-1973 levels. With an economic upturn, the argument goes, some of the cost crisis of health care will rectify itself.

Whether it's too late for the positive arguments about our health system to influence the changes that are ahead remains to be seen. At any rate, both sides of the story need to be told. We do have some inequities in our health system, including perverse incentives that must be addressed, but we must be certain that reforms don't destroy the strengths of the system we have. ❑

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commentary

New guidelines for treating major depression

Andrew Morrison, M.D.
Indianapolis

Fortunately, our society is finally beginning to give depressive disorders the attention they so direly need. Why is the need so dire? National Institute of Mental Health (NIMH) epidemiological studies indicate that the likelihood of a man experiencing a depressive disorder at least once in his life is 10%, and the odds are 25% for a woman. Left untreated, the pain and misery these people endure is inhumane, and 15% of them kill themselves. When treated, 80% to 90% of these people respond, a better success rate than such commonly accepted treatments as angioplasty and atherectomy. NIMH studies show that two out of every three cases of a depressive disorder go untreated.

This year, the National Mental Health Association's campaign to increase the general public's awareness and knowledge of depressive disorders is saturating the United States. By the end of the year, the average American will have been exposed 11 times – through TV, radio and print ads – to the three main prongs of the message. Perhaps you have seen or heard the message yourself. The three main prongs are: clinical depression is a medical illness; effective treatments are available; and see a doctor for help.

We hope access to treatment of depressive disorders improves soon. Not only will more Hoosiers be recognizing depressive disorders when they or a loved one has one, their access to treatment should also be improved. For years, insurance benefits have discriminated against the treatment of depressive disorders. They were anachronistically conceptualized as mental not physical illnesses. As we all know now, there is no "either-or" to it; the mind-brain-body trinity is an entity whose component parts overlap and whose boundaries are undefined.

Insurance plans in the future, no matter what the final form looks like, will probably include improved benefits for the treatment of depressive disorders. The American Medical Association's Health Access America and supposedly Mrs. Clinton's reform package both advocate covering depressive disorders (the "mental" illnesses) on a par with the physical illnesses.

So, when people do go to their doctor for help, will we drop the ball? In the never-ending quest for improved treatment, leading psychiatric researchers pooled their data and reached a consensus on the principles of treating major depressive disorder in adults. The American Psychiatric Association published these parameters in April.[1]

In treating major depressive disorder in adults, the practice guideline treatment principles emphasize not only the goal of gaining improvement, but also maintaining improvement. "Treatment consists of an *acute phase*, during which remission is induced; a *continuation phase*, during which remission is preserved; and a *maintenance phase*, during which the susceptible patient is protected against the recurrence of subsequent depressive episodes."[2] The emphasis is on preventing relapse.

A variety of treatment interventions may be used alone or in combinations for the different phases of treatment. All primary care physicians should be familiar with the antidepressant medications, including the newer selective sertonin-reuptake inhibitors. Furthermore, the importance of psychotherapy cannot be overestimated. There exists a broad range of psychotherapeutic approaches, allowing individual tailoring for each patient on the basis of that person's particular condition and coping capacities. (However, rare is the primary care physician who has the time and training to do more than supportive psychotherapy.) Electroconvulsive therapy (ECT) and light therapy also should be available to patients with major depressive disorder.

A variety of interventions may be useful in psychotherapy. In addition to supportive psychotherapy, traditional psychodynamic psychotherapy and psychoanalysis may prove beneficial to some patients. Marital therapy and family therapy are often helpful, since marital and family problems frequently occur in the course of major depression. Group therapy is useful, with patients frequently stating "I feel better in knowing that I'm not the only one with this," as well as benefiting from the example of others who are successfully dealing with their depression, and from the support of the group. Behavior therapy, cognitive behavior therapy, interpersonal therapy and grief therapy are other types of psychotherapy that may be useful in treating major depressive disorder. Although these are presented here as distinct and separate entities, a combination or synthesis of these various approaches and strategies is commonly employed.

Psychotherapy alone may be sufficient and effective for patients with depression of mild severity

and/or primarily situational forms of depression. However, if the symptoms do not respond to psychotherapy, somatic treatment should be considered. If the major depression is moderate to severe or chronic, treatment generally requires medication with psychotherapeutic management. As severity increases, somatic intervention becomes progressively indicated.

Bereavement is commonly accompanied by the signs and symptoms of major depression. "Data indicate that almost one-quarter of bereaved individuals meet the criteria for major depression at two months and again at seven months and that many of these people continue to do so at 13 months. Although psychiatrists formerly believed that in most cases there is little reason to treat the depressive symptoms of bereavement with antidepressants or psychotherapy, it is now recognized that these treatments should be used when the reaction to a loss is particularly prolonged and psychopathology and functional impairment persist."[3]

Measuring antidepressant medication blood levels is helpful with many antidepressants, particularly nortriptyline, desipramine and imipramine. For example, when a patient has displayed an inadequate response to a medication and a decision must be made about changing the dose or the medication, a blood level can be invaluable. Furthermore, when a blood level may be affected by the presence of another medication or by an individual's atypical metabolic rate (such as in the aged), a blood level can help determine not only a therapeutic level but a dangerously toxic level.

ECT has an undeserved reputation among the lay public as being "dangerous or primitive" or causing "brain damage." However, "ECT has the highest rate of response of any form of antidepressant treatment and should be considered in virtually all cases of moderate or severe major depression unresponsive to pharmacological intervention. Approximately 50% of medication-resistant patients exhibit a satisfactory response to ECT."[4] In the most severe cases of major depressive disorder, ECT plays a greater role as a primary treatment. Although ECT is not usually regarded as a first-line treatment, it should be considered as a first-line treatment for severe major depression when accompanied by psychotic features, severe suicidality, food refusal leading to nutritional compromise, catatonia or other situations in which a rapid response is required.

"Continuation treatment is based on the premise that there is a period of time following symptomatic recovery during which discontinuation of the treatment would likely result in relapse. The available data indicate that patients treated for a first episode of uncomplicated depression who exhibit a satisfactory response to an antidepressant agent should continue to receive a full therapeutic dose of that agent for at least 16 to 20 weeks after achieving full remission,"[5] usually in combination with an appropriate psychotherapeutic program. Patients who have had multiple episodes of depression should be considered for maintenance medication treatment.

Maintenance treatment is indicated for those patients who are prone to recurrence. "Depression is, for many, a recurrent disorder. Among those suffering an episode of major depression, between 50% and 85% will have at least one lifetime recurrence, usually within two to three years."[6] For these patients, continuous prophylactic drug treatment may be best continued for a prolonged period of time, in some cases indefinitely.

Depressive disorders are prevalent enough to have personally touched the lives of every Hoosier physician. Is there one amongst us who has not known somebody who has committed suicide? Many of us have loved ones who have suffered from a depressive disorder. Some of us have had it. It needs to be diagnosed and treated. ❑

The author is an Indianapolis psychiatrist and chairman of the Mental Illness Awareness Coalition.

References

1. Practice guideline for major depressive disorder in adults. *Am J Psychiatry*, 150(4):supplement, 1993.
2. Ibid, p 4.
3. Ibid, p 8.
4. Ibid, p 12.
5. Ibid, p 10.
6. Ibid, p 11.

Medicaid official hopes

Bob Carlson
Indianapolis

If you haven't met Denise Ingram-Bradley, M.D., M.P.H., from the Indiana Office of Medicaid Policy and Planning, chances are good that you soon will. She is responsible for implementing the new primary care case management (PCCM) plan for Indiana's Medicaid program and for recruiting primary care physicians to participate in the plan.

When Assistant Secretary for Medicaid Policy and Planning James Verdier told INDIANA MEDICINE earlier this year (March/April issue) that a PCCM plan was in the pipeline, Dr. Ingram-Bradley was already preparing the claims analysis data for the state's application to the federal government. Indiana's application for a federal waiver was approved, and Dr. Ingram-Bradley has been coordinating efforts to get the plan off to a smooth start next July.



Twenty-five states already have PCCM plans for their Medicaid programs. The dollar savings attributed to these plans have been modest in proportion to state Medicaid budgets. In Indiana, the PCCM plan is expected to save $5 million of state money in fiscal 1995. That's less than 1% of the projected $1.306 billion in state Medicaid expenditures for the same fiscal year. Still, for Medicaid administrators, every million saved is a million earned.

The real payoff from Medicaid PCCM plans has been better health care for Medicaid recipients and the kind of doctor-patient relationships that physicians enjoy with their privately insured patients. "It's a better way to practice medicine," says Dr. Ingram-Bradley. In this interview, she elaborates on the benefits of the plan, outlines its mechanics and talks about the intensive preparations now under way for the plan's inauguration July 1, 1994.

Dr. Ingram-Bradley has served as chief medical consultant of the Indiana Office of Medicaid Policy and Planning in the Family and Social Services Administration since 1991. She received her medical education at Harvard Medical School and Harvard School of Public Health and completed a medical epidemiology fellowship at the Centers for Disease Control in Atlanta. She is a clinical assistant professor of pediatrics at the Indiana University School of Medicine.

She previously was director of the Bureau of Family Health Services at the Indiana State Department of Health, where she led and supervised the divisions of maternal and child health, nutrition/WIC, dental health and child specialty services. She has been the principal investigator of five federally funded research and grant projects and has received many awards and recognition for work and publications in the area of maternal and child health and infant mortality prevention.

INDIANA MEDICINE: **Would you explain the primary care case management plan being implemented for Medicaid patients in Indiana?**

Ingram-Bradley: Primary care case management (PCCM) is one of the common forms of managed care that 25 states around the country have implemented. Basically, it allows patients to have a medical home, in that there is a primary care physician who will either provide or arrange for basic

plan improves access

preventive and primary care. It allows for the formation of a true doctor-patient relationship, which many of us enjoy with private insurance. The primary care physician is responsible, too, for determining the medical necessity of specialty care and referring, when necessary. That's the basic philosophy, which doesn't sound too revolutionary when you think of it. What we're basically trying to do is mainstream Medicaid patients as much as possible, treat them like we treat regular private patients.

Because you allow and encourage that doctor-patient relationship, appropriate care is encouraged, and duplicative care and inappropriate use of certain settings such as emergency rooms are discouraged. The quality of care provided actually increases because care is being performed when it should be, how it should be and by those who should provide it. And as a result, cost is contained and in effect, decreased. That's been shown to various degrees in states that have implemented [PCCM].

Medicaid programs across the country of course are under fiscal challenge, and this type of managed care plan is one of the shining stars. People seem to like the plan, and it actually does pretty good things. Physicians in general like the plan. Patients like the plan because they really have a doctor. And the administrators of Medicaid like the plan because we can save some money. We hope we'll be able to do that in Indiana.

INDIANA MEDICINE: **How will physicians be affected by this plan?**

Ingram-Bradley: Policies will change in how they currently relate to Medicaid. One of the things we will ask is that they or their staff be available to address patients' needs after 4 p.m., or after regular work hours, which is what happens in a regular practice. We will pay a monthly per-patient management fee for being available to patients when needed. Regular care will continue to be billed fee-for-service, as it is currently. There will be no capitation in this plan.

Physicians are affected positively because they now have more control over the patients' care. Patients can only go to them for their routine, non-emergency care. [Physicians] know where the patient is in terms of their treatment regimen, and they have control over it. It really allows them to practice medicine in a way that they have been trained to do and the way they do for the rest of their patients. It's so difficult to start a treatment regimen and then not see the patient for four or five months and they come back and you don't know what has gone on. They may have visited the emergency room, and there are so many other unknowns that you have to start all over again. That kind of thing will no longer be allowed under PCCM. Of course, if patients have an accident or some other medical emergency, they can go to any emergency room and be seen and possibly admitted, and then the primary care physician would be contacted once they're stabilized.

> ***"Basically, it [PCCM] allows patients to have a medical home, in that there is a primary care physician who will either provide or arrange for basic preventive and primary care."***



INDIANA MEDICINE: **What portion of the Medicaid population will this plan affect?**

Ingram-Bradley: We will be starting the plan in Indiana initially for the Aid to Families with Dependent Children, the AFDC population, and what we call related populations. Those are the near-poverty people who are on the Medicaid program. We feel that the best experience and the most success have been achieved in this particular group because they benefit most definitely from

providing early, basic preventive and primary care. It helps improve their health status by getting this care early on and having a consistent source of care.

[The plan] will not include the aged or disabled populations in the state.

This is our first entry into this area, and we hope to use it as an education for how to set up different types of managed care plans for other populations. The disabled and aged probably need more of a critical care type of plan than a primary care plan.

INDIANA MEDICINE: **In what counties will the plan be implemented first?**

Ingram-Bradley: The counties that will come on in the first year include Clark, Fountain, LaPorte, Marion, St. Joseph, Tippecanoe, Vigo and Warren. The second year, the counties added will be Allen, Delaware, Elkhart, Floyd, Lake, Madison and Vanderburgh. The remaining 77 counties, which comprise a third of the state, will be brought on in the third year.



INDIANA MEDICINE: **When you say a third, do you mean population?**

Ingram-Bradley: Yes, population. A third meaning a third of the AFDC and related groups who are eligible for Medicaid.

INDIANA MEDICINE: **Why were those counties selected?**

Ingram-Bradley: Two criteria were used to select the counties, and they resulted from the detailed epidemiologic claims analysis that I performed in November. One criterion was highest cost per recipient, knowing that we would probably get the most savings from those counties. The second criterion was adequate numbers of primary care physicians already working with the Medicaid program because we felt we would be able to recruit those physicians relatively easily.

INDIANA MEDICINE: **When will the plan begin?**

Ingram-Bradley: July 1, 1994. This program will be mandatory and phased in over a three-year period of time. It will be 1996 before we're fully implemented.

INDIANA MEDICINE: **What are the goals of the plan?**

Ingram-Bradley: To increase access, to enhance quality of care and to save money. Those are the three goals and they work in concert.

INDIANA MEDICINE: **How much money is the program expected to save?**

Ingram-Bradley: Very detailed analysis has gone into this. We expect to save, on average, $5 million state dollars a year. When you look at the federal savings, it's much more. [The savings will result] primarily from controls on overutilization. We predict that providing patients with a solid doctor-patient relationship will decrease the routine use of emergency rooms as well as doctor shopping, in which patients go from one doctor to another and all the lab, x-ray, office visits and procedures are repeated.

INDIANA MEDICINE: **Who meets the definition of primary care case managers? For example, are all internists included?**

Ingram-Bradley: Case managers will only be primary care physicians, including family practitioners, general practitioners, pediatricians, ob-gyns only for pregnant women and internists who have a primary care mode of practice. Those who are specializing or sub-specializing are not eligible to be case managers. Those who provide all aspects of general primary care will be.

Any setting that these physicians perform in will be eligible. If they're in a group practice, they will be eligible to participate. If they work in a clinic, either a free-standing clinic or a federally funded clinic or a private clinic, they would be eligible to participate. When there are patients whose physician works in a group practice or a clinic, we want to identify what we call a principal rendering provider, so that if there's a specific concern about a patient, we have an individual who knows about the case. And

that is typical in most group practices as well as clinics, that there is someone who is ultimately knowledgeable and following the care of those patients. That is also something that the Health Care Financing Administration encourages to maintain continuity and for accountability purposes.

There may be circumstances in which other types of specialists are allowed to be primary care providers. But that would only occur on a case-by-case basis. We see that as occurring in particular with children who have complex medical problems, with the majority of their care being provided by a certain specialist. If it's in the best interest of that patient to maintain that relationship, we will allow it.

INDIANA MEDICINE: **And ob-gyns?**

Ingram-Bradley: The ob-gyn is a unique case for us, and they definitely will be primary care providers for the pregnant woman.

INDIANA MEDICINE: **When the pregnancy is over with, is that situation reevaluated?**

Ingram-Bradley: There are a number of scenarios, but if that person is eligible for Medicaid after the pregnancy, they will be given a different type of primary care provider, either an internist, if they're an adult, or a family practitioner. If they are no longer eligible, they will go off the program.

INDIANA MEDICINE: **If the primary care case manager is on call 24 hours a day, seven days a week, what happens when the physician goes on vacation?**

Ingram-Bradley: When a physician goes on vacation, someone covers for him. It's the same situation here. We will pay for care once the case managers let us know who will be covering in their absence. Care will continue as normal, as it does in the private sector. We're trying to make this program as close to what is going on in the real world as possible. We want Medicaid patients to fit right into a regular practice, like everyone else.

> *"We're trying to make this program as close to what is going on in the real world as possible."*

INDIANA MEDICINE: **Do you envision co-payments being implemented as part of this plan?**

Ingram-Bradley: Well, you probably recall that back in March when Gov. Bayh announced his Medicaid initiatives, co-payments were a part of it. We are governed by federal law in this area, which does not allow us to have co-payments for children up to age 21, or 18 in certain instances. For adults, one of the initiatives that the governor has announced is that when patients continue to use the emergency room for routine care once we have the system in place, they will have to pay a portion of that care.

INDIANA MEDICINE: **How about co-payments as just part of the regular functioning of this plan in Indiana?**

Ingram-Bradley: Sixty-five percent of AFDC and related groups are children, so that the impact of co-payments is going to be minimal in this program. The [inappropriate] use of emergency rooms is the only area where co-payments will be attached. But it is kind of like a test case to see how that operates, and then possibly under the limits of what federal law allows, we will look into expanding that. But right now that's the only area that will be targeted.

INDIANA MEDICINE: **What happens if a patient goes to the emergency room for non-emergency reasons or visits a specialist even though the primary care case manager has told the patient this is not allowed?**

Ingram-Bradley: Let me take the second part first. In this year coming up, through a number of mechanisms, we will inform all Medicaid-enrolled providers about this plan and what it means. How referrals must take place will be an integral part of that. The primary care physician working with the patient will decide, based on medical necessity, if a patient needs to see a specialist. They will with that patient decide which specialist they will refer to, and there will be the necessary exchange of information so that the specialist will be paid. If the patient goes to the specialist without the consent of the primary care physician, and that specialist sees that patient

and provides care without the approval of the primary care physician, that specialist will not be paid for that care.

What I'm saying is that we will inform the specialists and other Medicaid providers that if a patient comes to you and has not been directly referred by their doctor, and their Medicaid card will have on there the doctor's name who is responsible for their care, do not see this patient. Because if you do see the patient, we will not pay you. We plan to make sure that everyone understands that, the specialist as well as the primary care physician. Patients will test the system, as you can well imagine, and we really don't want to have services provided that won't be reimbursed.

INDIANA MEDICINE: **If a primary care case manager has not authorized an admission to the emergency room, what is the emergency physician supposed to do?**

Ingram-Bradley: If a patient comes in and is not immediately perceived as an emergency, the primary care physician is contacted and must give approval to see that patient. Of course, if it's a bona fide emergency, there's no need or time to contact a physician to get approval. But if there's a case that's a question, then once it's communicated to the primary care physician, if he or she gives their approval, there's no problem.

INDIANA MEDICINE: **In a questionable situation, if the use of emergency facilities turns out to be not warranted, is care refused?**

Ingram-Bradley: We will not be second-guessing physicians' decisions. We really are trying to build a physician/provider-friendly system where we believe physicians, when given a realistic system, will just practice medicine as we expect them to. Once that decision by the primary care physician has been made, that this is an emergency and I want this patient to be seen, we will not on Monday say, was that realistic or not?

What we will be doing, as required by HCFA, is monitoring utilization by each physician and comparing them to each other. When there are outliers, meaning that when physicians are two and three standard deviations outside the norm in terms of their emergency room approval, then those are flagged [as cases] that we would like to look into. As with any payment source, we have to monitor what's going on and we will be evaluating you against your peers.

INDIANA MEDICINE: **If a patient is referred to a specialist, how does the plan work? Who does the paperwork? Who chooses the specialist?**

Ingram-Bradley: We want to encourage patient and physician to maintain continuity and allow that patient the choice of specialists whenever possible. One of the benefits of this program is that the patient has the benefit of the primary care physician's ability to select a specialist for them. Of course patients will be informed about that, and we hope they will agree. Once that's done, just like in regular medical practice, we will require an exchange of information that is critical for the specialists to put on their claims, [to indicate] that this is clearly an approved referral.

We will of course need a paper trail of documentation on the patient record, and the result of that consultation has to be sent back to the referring physician. But that's the normal routine. We want chart documentation for audit purposes later on, as it occurs in any consultation.

INDIANA MEDICINE: **As far as choosing the specialist, there seems to be considerable latitude for professional judgment.**

Ingram-Bradley: Exactly. And just as with any situation, we want to bring the patient in on that decision. If there is a specialist that they have visited in the past and have seemed to be satisfied, we hope that the primary care physician gives the patient the benefit to go back to that same specialist. We're really trying to maintain continuity and existing workable, positive relationships. We do not plan, in any instance, to disrupt care that's going well.

INDIANA MEDICINE: **How will you help patients understand the new rules of this plan?**

Ingram-Bradley: First of all, we can learn a lot from the experiences of other states. Some did not put as much attention into the education of the recipients, and things did not work out as planned. At the time of enrollment onto Medicaid, what we call recertification, patients will be given an orientation in the local offices. It will be a recipient-friendly video, interactive and

age- and education-appropriate, with time for questions and answers. They'll be shown how to pick a physician and why this program will benefit them. We will do that on several different occasions. We'll have a captive audience because with the reorganization of the agency here, [enrollment for] food stamps, AFDC payments and Medicaid all occur at the same time. While they're in the waiting room, they'll have the video. That will be reiterated with a face-to-face interview as well as group educational intervention. We have people now planning that.

It is going to take some time for everyone, physicians and patient alike, to become used to these changes. There is going to have to be a behavioral change on the part of patients to really know that when I'm sick at night, I have someone who can deal with my problems and I do not have to run to the emergency room, which I've been doing because there hasn't been anyone there for me to contact or relate to. There's going to be a systematic and continuous education program about how the program operates, what appropriate use of emergency rooms is and when and how and at what time you should contact a physician. Education about the importance of preventive care and the importance of primary care and how this is in the best interests of their health maintenance will occur. Physicians have told me that this is critical to their taking on new Medicaid patients and the program working well. And that has definitely been the experience around the country, that if you don't spend a lot of time educating the patients about the changes, and about the need for this kind of primary care, that the program won't work well and people won't be happy.

[Education] will also extend to service delivery. Many times you hear physicians say, well, the Medicaid population is very difficult to work with because they miss a lot of appointments and it's sometimes disruptive to a practice. We're planning a program so that there will be communication between the physician and someone to assist him or her in their office when patients miss appointments, to address those social-related problems that they just don't have time to address. We're real excited about that because we believe that in order for medical care provision to work well, some of those other aspects of health care must also be addressed, so that patients are available to follow a treatment regimen.

INDIANA MEDICINE: **Are there any mechanisms in place for feedback from physicians?**

Ingram-Bradley: We will have provider relations services staff whose job is to do just that. There will be a hot line that the physicians can call with specific problems. We do plan to have people



available before the program starts as well as during it to assist in all aspects, not only in terms of bulletins but actually face to face as often as possible.

INDIANA MEDICINE: **If you were in private practice, how would you feel about this primary care case management plan?**

Ingram-Bradley: It's not easy to find programs which the patients, the physicians and the payer enjoy. It takes a lot to plan it well and that's what we're doing. We're glad that we have 11 months still ahead of us for that. But to answer your question, I would sign up immediately. ❑

This interview was conducted by Bob Carlson, a health care communications consultant in Indianapolis.

Consultants urge doctors to prepare for future

Kathy Whyde Jesse
Beavercreek, Ohio

With apologies to Ben Franklin, nothing in this world is certain, except death, taxes and a major restructuring of the American health care system.

Health system reforms are just around the corner, and the physician who doesn't prepare now for the changes will be left behind, health care consultants say.

Right now, "doctors are dealing from one perspective – fear," says Michael Brown, president of Health Care Economics Inc., an Indianapolis-based company that helps physicians across the nation with issues of regulation, reimbursement and strategic planning. "They need to quit being so fearful and prepare for the future." To Brown, that means diversification. "People want one-stop shopping," Brown says. "If you're a family practitioner, that means have a lab and x-ray. If you're an ophthalmologist, you shouldn't just be doing cataract procedures. Don't put all your eggs in one basket. Control your own destiny."

Across the country, primary care physicians are banding together with specialists, forming independent practice associations, or "clinics without walls." As a unit, they can offer their services to employers, insurance plans or to third-party administrators. They may agree to deliver their services on a capitated basis – a monetary limit set on services by the insurance company.

There will be larger group practices, predicts Joseph E. Gordon of the Indianapolis Ent & Imler CPA Group, which consults with physicians and others in the health care industry. "Where there are three doctors, they may go to eight," he predicts. "They can negotiate contracts with large insurers and employers, but they're still independent."

This sort of networking raises some legal issues, according to Leah Mannweiler, a partner in the Indianapolis law firm of Krieg, DeVault, Alexander and Capehart. The firm represents a large number of physicians, hospital and physician practice groups. "Whenever you look at a collective arrangement, you have to look at credentialing, antitrust issues, what type of corporate structure is going to work for that particular network and tax ramifications. There are all sorts of legal and financial ramifications. It needs to be done carefully."

Compared to other states, Indiana has a very low percentage of patients who are participating in managed care plans, Mannweiler says. But she believes primary care physicians are going to have an increasing degree of importance after the reforms. "They are going to be the gatekeepers, referring patients to specialists."

She says President Clinton's reform plan emphasizes wellness. "Again, primary care doctors are crucially important in that effort."

Physicians can take a lesson from dentists, says Joe Suchocki, head of Eagle Associates, a national health care education consulting firm based in Ann Arbor, Mich. Dentists have made prevention the foundation of their practice. "Learn how to interact with patients," Suchocki suggests. "Teach them how to stay healthy. Have them come back every six months to make sure they're doing everything right.

"This will help contain the cost of health care."

Another option for physicians is to sell their practices to hospitals. Every major hospital in Indianapolis has gotten into the market of buying physician practices, Gordon says.

The hospital guarantees the physician's salary, takes care of all the paperwork and covers the physician's employees with its own benefit plan.

At first, the physician may feel unburdened of administrative hassles, Gordon says. "The physician feels, 'Now I can just practice medicine.'

"We call it the 'selling-your-soul-to-the-devil syndrome,'" Gordon says. "We're seeing a lot of problems where the physician has been doing this for some time. The doctor loses control of his practice, which is hard for someone who has had control their entire lives. They can no longer say, 'Well, I need to make some extra money this month, so I'll book some more patients and work some extra hours.' "

In addition, hospitals have a hard time billing for physicians' services. "It's a whole different area," Gordon says. "You use different forms, different codes. You have to retrain the billing staff or set up a separate billing office just to handle the

physician's practice."

Brown believes that the fear factor has influenced physicians to make irrational decisions, selling their practices for nothing. "Hospitals are buying up doctors hand over fist now," he says.

Suchocki says it's crazy for physicians to sell their practices to hospitals. "Hospitals cannot run practices. A hospital is a large-scale operation. A practice is a small-scale operation."

A better solution, according to Gordon, is for specialty practices to buy primary care practices. "They're securing their referral base. I think it's a better route in that you're still in your peer group. You still have a respected voice, more so than you would with hospital administrators."

Outcomes documentation may be another feature of the new health care reforms. Providers may have to record their success, or lack of it, in treating their patients.

Outcomes documentation may be another feature of the new health care reforms. Providers may have to record their success, or lack of it, in treating their patients.

Gordon feels that outcomes will be difficult to quantify. "I think there will always be exceptions to any type of model you build to measure it on. If you look at different areas, just in Indiana you will have wide-ranging results. We have all different types of populations. In Switzerland County, the average age is a quite a bit higher than in Hamilton County. And the per capita income is tremendously different. How do you build in every variable there is?"

But Suchocki thinks that outcomes documentation is a reasonable expectation. "It's all a part of business. You should be able to say what you've done, or not done, for customers. We need nationally a set of medical practice guidelines. We should be able to define what works. That should help to contain health care costs."

The fallout from the reforms will most likely be what physicians don't want to hear: They'll have to run their practice like a business.

"Doctors don't like to hear the word 'marketing,'" Suchocki says. "They feel it is unethical to advertise. But what they don't realize is, they're in a very competitive business.

"Historically, they just opened their door and patients just flocked in. But now, with HMOs and managed care, there will be limits on how much they will be paid."

They need to set up policies, procedures and operational guidelines in writing. "There are practices out there that do a half a million to one and a half million dollars a year in business, and they're running it without a plan," he says.

On the average, he says, a practice may lose from thousands to tens of thousands of dollars a year because it doesn't collect fees owed to it or the wrong billing codes are used, and the practice doesn't receive full reimbursement.

"The message is this: The average physician has to consider he runs a business just the same way the guy down the street runs a shoe store.

"I tell any physician, 'You've got to convince me you're willing to run your practice like a business. If you're not, you're wasting my time and I won't take you as a client.' "

What should a doctor consider in determining whether to join a managed care plan? Evaluate the reimbursement policies, Gordon advises. Evaluate the provisions for dropping the contract. Identify the demographics of the patients.

"If it's a General Motors plan that just covers retirees, you've got to know that up front. The best thing a physician can do when presented with a managed care contract is to get legal and financial counsel. Those two go hand in hand."

The physician is the cornerstone of health care in this country, Suchocki says. "Our mission is to help private practices survive. If they don't, health care in this country won't survive. There's nothing wrong with health care in this country that can't be cured by good accounting and measurable successes." ❑

The author is a freelance writer and former Indianapolis Star *reporter.*

Physicians fine-tune offices with PA/QI program

Adele Lash
ISMA Communications Director

If early responses to the ISMA Practice Assessment/Quality Improvement (PA/QI) Program are any indication, the pilot project is reaching its goals. Begun in 1992 as part of the AMA/Specialty Society Medical Liability Project, PA/QI is being piloted in eight states, including Indiana. The pilot is limited to physicians in family practice, internal medicine and pediatrics. Results of the pilot project will determine if the AMA expands PA/QI into a national model for effective risk management education for all medical specialties.

The program is designed to reduce physicians' risk of liability suits through self-assessment of office practices and procedures, comparison of those procedures to colleagues nationwide and follow-up to make changes as necessary. PA/QI includes a self-assessment survey, a home study course that contains actual case studies and an on-site office survey.

So far, 83 ISMA members have signed up for the pilot study. The program has been offered by the ISMA with the assistance of Physicians Insurance Company of Indiana. What do some of the early participants who have completed the program say about PA/QI?

"The PA/QI program allowed me to focus on and correct potential risk management problems in my office," said Michael R. Williams, M.D., a solo family practitioner from North Webster. He changed several office procedures as a result of the program. For example, he developed new reminder systems for follow-up exams and to verify that patients had seen consultants and had followed through with receiving diagnosis evaluations. The program also raised awareness about the need to track narcotics and secure prescriptions in the office setting.

> ***"The PA/QI program allowed me to focus on and correct potential risk management problems in my office."***

"The adjustments we made in the office were all changes for the better," Dr. Williams said. He noted that the review of office practices and procedures was thorough and well-received by his staff. "I would recommend the program to anyone interested in reducing liability risks," Dr. Williams said.

Frank J. Amodio, M.D., an Evansville internist who specializes in treating allergies, was enthusiastic in his praise of PA/QI. When asked how he rated the program, he responded, "Excellent. I would highly recommend the program to every physician no matter what specialty.

"One problem is that in medical school we do not receive much training in understanding quality control in protecting ourselves on malpractice. We're alone out here." The PA/QI program helped him answer the questions: "Do we have the right idea and are we going in the right direction (in terms of risk management)?" He particularly liked the hands-on aspect of the program, which he said sets PA/QI apart from lecture risk management programs.

He thought the practice reviews were particularly helpful and said he enjoyed doing them. Overall, he said the PA/QI program reinforced for him and his staff the importance of documentation in the medical record. Although he made no drastic overall changes in his medical practice, "we fine-tuned a few things."

"Every once in a while, you have to do this," Dr. Amodio said of risk management education in general. "It's like reviewing anything in medicine."

For Pamela S. Higgins, M.D., assistant clinical director of Memorial Hospital's Family Practice Center in South Bend, the value of PA/QI goes beyond her own practice. She's using the practice reviews in conferences with the resident physicians in the hospital's family practice residency.

"We have noon conferences on various topics, but the difference is (in using the case studies) that if you can show people actual

cases and how they were handled, people learn more easily." The practice reviews are part of the home study portion of PA/QI. They contain five hypothetical physicians and details of actual medical malpractice claims. PA/QI participants are asked to determine why the doctors in the case studies were vulnerable to a liability suit and indicate how their exposure could be reduced.

Dr. Higgins said two recurring themes occurred to her throughout the PA/QI program: the importance of communication and documentation. "In a hospital setting, there are many people who need to be part of the communication process. And documentation is essential. That's what I keep trying to impress upon the residents."

Elwood family physician, Robert J. Helm, M.D., said he signed up for the PA/QI program because it sounded interesting.

"Anytime you get the opportunity to pick up suggestions of what you can do to decrease your risk of being sued, you should go after it," he said. While the program pointed out change areas, Dr. Helm said he would have liked more feedback in how to make the changes.

He said he had attended lectures on risk management before, but PA/QI got his office staff involved too.

In Bedford, where Deborah Williams Craton, M.D., is beginning her 10th year in practice, the PA/QI program reinforced the good office practices she and her staff had developed while indicating where changes needed to be made.

"Our office tries to be progressive. We try to keep up with quality improvement both clinically and in our office procedures." Although she participates in a program on clinical quality improvement, "that doesn't always protect you against liability." The biggest change she and her staff have implemented is how they handle phone calls. "We did fine taking the calls and calling in prescriptions, but we didn't do well in documentation."

Dr. Craton did all three parts of the program, but says if doctors do only the first two parts, they will find it worthwhile. "The questionnaire (part 1) helped us make a lot of changes before we even did the in-office survey (part 3)," she said. And the office survey was a non-intimidating way to reveal both to her and her staff what they needed to change, while reinforcing what they were doing well, she noted.

"An objective self-assessment" is how Thomas A. Kintanar, M.D., described PA/QI. Dr. Kintanar of Fort Wayne has been in family practice for seven years. He said the program pointed out strengths and weaknesses and provided learning and reinforcement in a non-threatening manner. "It brings you down to reality and was very worthwhile in helping me learn the standard."

As the PA/QI pilot program continues, physicians who wish to sign up should call Barbara A. Killila, PA/QI project coordinator, at 1-800-284-7424. ❑

Alternative minimum tax covers more types of income

Joel N. Blau, CFP
AMA Investment Advisers, Inc.
Chicago

President Clinton's current economic proposals include a potential increase in the alternative minimum tax (AMT) rate.

The AMT generally affects a limited number of taxpayers; however, you could be subject to the AMT one year and not another, especially when there are changes in tax laws and rates. If you understand the AMT and what typically triggers it, you can take steps to minimize your tax liability.

The AMT is a separate tax system parallel to the ordinary federal income tax system. Its flat rate of 24% is comparatively low, but the rate applies to a broader base of income than regular income taxes. It also may increase to about 26% if President Clinton's proposal becomes law.

The purpose of the AMT is to make sure that every taxpayer pays a "minimum" amount of tax. It usually affects high-income people who may reduce their tax liability extensively through the use of certain exemptions and deductions.

The AMT includes certain types of income (known as preference items) not taxed under the ordinary system, and it disallows certain deductions (known as adjustments) permitted with the regular system.

For example, it includes as taxable income the interest received from certain municipal bonds issued after Aug. 7, 1986, the bargain element of an exercised incentive stock option and unrealized capital gains on certain types of appreciated property donated to charity. Among the disallowed adjustments are personal exemptions, the standard deduction and miscellaneous itemized deductions.

However, you are not necessarily subject to the AMT if you have AMT preference items and/or adjustments. You are subject to it only if your AMT tax liability exceeds your ordinary income tax liability for the year. The best way to determine which tax you must pay is to have your tax adviser estimate your tax both ways.

Consult your tax adviser if you are concerned about the AMT. Your adviser can provide more detailed information and help you select appropriate strategies for your situation. ❑

The author welcomes readers' questions. He can be reached at 1-800-262-3863.



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Doctor travels back in time on military cycles

Tina Sims
Managing Editor

Ronald Andrews, M.D., likes to daydream that it's 1943. He imagines he's thousands of miles from his New Palestine home, perhaps in a steamy jungle in the South Pacific.

Such fantasies set the mood when Dr. Andrews retreats to his garage to work on his hobby – restoring World War II military motorcycles.

"I love these bikes because they're almost pieces of art now," he says.

Motorcycles have always fascinated the family physician, who practices in Greenfield. While growing up on a farm, he convinced his parents to let him have a motorcycle. His sisters rode horses, but since he didn't like horses, why couldn't he have a motorcycle? he argued. He depended upon a motorcycle for transportation through college and toured 49 states on his cycle during a four-month trip in 1970.

Although he joined the Marine Corps after high school and spent two years in Vietnam, he didn't have the chance to ride motorcycles during his tour of duty. Motorcycles were discontinued for military use in the 1950s, he explains, but were reintroduced shortly before the Persian Gulf War.

Dr. Andrews bought his first military motorcycle 12 years ago from a man in northern Indiana and spent three years restoring it. He now owns 20 military cycles and is president of the Indiana chapter of the Military Vehicles Collectors Club.

Restoring the motorcycles is a time-consuming hobby that begins with the search for an authentic vehicle and doesn't end until the motorcycle is restored and accessorized down to the goggles that the motorcycle soldier would have worn. Because Dr. Andrews prefers to use original equipment in restoration, the hunt can involve months, even years, of letter writing and phone calls.

He especially enjoys the restoration work. Although he can handle most of the tasks, such as stripping, painting and replacing missing parts, he sometimes leaves the engine repair to a specialist who has the right tools for the job.

He goes to great lengths to achieve an accurate restoration. He called on the services of a paint manufacturer to match the original color of an M72 Russian motorcycle scarred by bullet holes. The bike, equipped with a sidecar, was built in 1942 and left in a barn in Poland after the war. The next owner was a German preacher who used it for transportation for his family.

Occasionally he will find a motorcycle that doesn't need restoration. "If I can get away with the original, I don't touch it," he says. His 1941 Indian motorcycle, for example, was assembled from



Dr. Andrews shows his M72 Russian motorcycle that he spent three years restoring.

an engine found in its original box in Charleston, S.C., and a bike found in Indiana. "It's exactly the way it came off the assembly line," Dr. Andrews says. "I'll never ride it."

Equipping the bikes with genuine accessories and soldiers' personal items is particularly satisfying. He scours antique stores, flea markets and magazine ads for items such as first aid kits, helmets, boots, tools, goggles and toiletry kits that provide a "capsule history" of each motorcycle and its rider. Such attention to detail, he believes, is significant because it reflects the almost personal relationship a soldier had with his motorcycle. "This was their baby," he says.

He is equally dedicated to pursuing the history of each vehicle. "If I weren't a doctor, I'd be a college level historian," he says. He learned, for example, that his Italian Moto Guzzi was originally shipped from Addis Ababa, Ethiopia, in 1935, left in the Tunisian desert in 1942 and ridden by an American GI until 1945, when it was abandoned in Casablanca. Eventually the bike ended up in Cincinnati.

While showing his Harley-Davidson XA at a military motorcycle exhibit, he learned from a visitor that some of the bikes, intended for desert use, were sent to Hawaii by mistake. The visitor said he rode an XA while stationed at Pearl Harbor. Dr. Andrews gave this information to Harley-Davidson, which was not aware of the destination of some of its bikes.

After corresponding with a military museum in Moscow about the history of his M72 cycle, he learned it is the only such cycle in the United States.

Many military cycles were destroyed or left overseas after World War II ended. His collection doesn't include any Japanese motorcycles because many of them were left in jungles, where they rusted so badly they could not be restored. In addition, the Japanese are keeping the cycles they were able to salvage.

Historic military motorcycles are hard to find now that the hobby has become popular. "The supply now has really dried up," whereas once no one wanted the old cycles, Dr. Andrews says.

As the supply has dwindled, the value has increased. Collectors used to pay between $300 and $600, but "now you can't touch one for less than $8,000 to $15,000," he says.

"We're really preserving a big piece of American history that would be lost," he says. Although military museums used to consider private collectors as competition, they now realize they should work together.

"The most amazing thing is that so many of these bikes are still running," Dr. Andrews says. "I would have no trouble driving this 50-year-old vehicle across the country," he says of his Harley WLA.

He credits their durability to the workers who assembled the motorcycles. "They did the best job they could because they knew an American life would be depending on it," he says.

He also collects military bicycles. One of his most prized bicycles was ridden during World War II and used in the movie "The Longest Day."

His garage houses his expanding collection of military vehicles, equipment and mementoes. Helmets line the shelves, and guns and assorted backpacks and cartridge belts hang from the walls. Hundreds of books on World War II provide details that guide Dr. Andrews in restoring the cycles.



Dr. Andrews' collection of military memorabilia includes this mannequin modeling World War II camouflage wear.

As word of Dr. Andrews' collection has spread, he is often asked to ride his cycles in shows or parades. Next year he will travel to Fort Knox, Ky., to participate in a ceremony marking the 50th anniversary of the Normandy invasion. In 1991, he led a parade in Indianapolis in observance of the 50th anniversary of World War II.

"It's like any hobby," he says. "Once you get hooked, it's almost an obsession." ❑

Indiana State Medical Association

1993 Annual Convention & Exposition

Friday, Oct. 15
Saturday, Oct. 16
Sunday, Oct. 17

Westin Hotel
Indianapolis

* House of Delegates
* Reference Committees
* Health System Reform Forum
* IMPAC Luncheon
* President's Night Dinner and Entertainment

Abridged schedule of convention events

Thursday, Oct. 14

2:30 - 4:30 p.m. ..... Board of Trustees meeting
6 - 7 p.m. ..... Board of Trustees reception
7 - 9 p.m. ..... Board of Trustees dinner

Friday, Oct. 15

7 a.m. - 5 p.m. ..... Registration
9 a.m. - noon ..... House of Delegates, first session
Noon - 7 p.m. ..... Exhibit hours
Noon - 1 p.m. ..... Past presidents' lunch
Noon - 1:30 p.m. ..... Lunch in exhibit hall
Noon ..... ISMA Alliance lunch
1 - 6 p.m. ..... Reference committees
5 - 7 p.m. ..... Reception in exhibit hall
8 - 10 p.m. ..... 7th District Afterglow
8 - 10 p.m. ..... 12th District Afterglow
10 - 11 p.m. ..... 8th District Afterglow

Saturday, Oct. 16

7 a.m. - 5 p.m. ..... Registration
7 - 10 a.m. ..... Breakfast in exhibit hall and exhibit hours
8 - 10 a.m. ..... Risk management seminar
10 a.m. - 1 p.m. ..... Health system reform forum
1 - 3 p.m. ..... IMPAC luncheon
3 - 5 p.m. ..... Health system reform reactor panel
6 - 10 p.m. ..... President's Night Reception and Dinner
10 - 11 p.m. ..... 1st District Afterglow

Sunday, Oct. 17

7 - 9 a.m. ..... Board of Trustees breakfast
9 a.m. - noon ..... House of Delegates, final session
Noon - 1:30 p.m. ..... Trustees organizational meeting and executive committee meeting ❑

Official call

The House of Delegates of the Indiana State Medical Association will convene at 9 a.m., EST, Friday, Oct. 15, 1993, in Grand Ballroom 5 of the Westin Hotel in Indianapolis.

The House will reconvene for its second (final) session at 9 a.m., EST, Sunday, Oct. 17, in Grand Ballroom 5.

Representation in the House for the 1993 annual meeting will be as follows:

Indianapolis – 38 delegates
Lake County – 14 delegates
Allen County – 12 delegates
Vanderburgh County – 9 delegates
St. Joseph County – 8 delegates
Vigo-Parke-Vermillion counties – 6 delegates
Delaware-Blackford counties and Owen-Monroe counties – 5 delegates each
Tippecanoe County – 4 delegates
Bartholomew-Brown, Elkhart, LaPorte, Madison, Porter and Wayne-Union counties – 3 delegates each
Clark, Daviess-Martin, Dearborn-Ohio, Fayette-Franklin, Floyd, Fountain-Warren, Grant, Harrison-Crawford, Howard, Jasper-Newton, Jefferson-Switzerland and Shelby-Rush counties – 2 delegates each
The remaining 50 Indiana county medical societies – 1 delegate each
Trustees – 17
Past presidents – 18
Resident Medical Society – 2 delegates
Student Medical Society – 4 delegates
Total voting members of the House of Delegates – 234. ❑

Convention includes specialty group meetings

Two specialty groups will meet during the annual ISMA convention.

The Association of Indiana Directors of Medical Education will hold its annual meeting from noon to 2:30 p.m. Oct. 15.

The semi-annual meeting of the Indiana Roentgen Society will be held Oct. 16. The executive meeting will begin at 7 a.m., followed by the general membership meeting at 8 a.m.

For information on these meetings, call Dotty Martens at the ISMA, (317) 261-2060 or 1-800-257-4762. ❑

Health system reform analysts to participate in forum

National and state leaders in health system reform will participate in a forum during the annual ISMA convention. The panel discussion, "The Road to Health System Reform," is scheduled from 10 a.m. to 1 p.m. Saturday, Oct. 16, and will be followed by a health reform reaction panel from 3 to 5 p.m.

Because President Clinton's health system reform plan is expected to be released in mid-September, the panel will discuss the impact of the new proposals and answer questions from the audience. The reactor panel, composed of representatives of the ISMA and of various consumer groups, will respond to comments made during the morning session.



Lynn Etheredge

At INDIANA MEDICINE press time, the following people had confirmed they would participate in the morning forum: Lynn Etheredge, a major architect of the managed competition idea; James Todd, M.D., executive vice president of the American Medical Association; Myra Selby, director of health care policy for the state of Indiana; and David Weinschrott, a research fellow at Hudson Institute in Indianapolis and author of a report titled "The Curable Crisis: Rethinking America's Health Care Priorities." Others invited who had not yet responded were Uwe Reinhardt, Princeton University professor and member of the Physician Payment Review Commission; Howard Dean, M.D., governor of Vermont and chairman of the Health Subcommittee of the National Governors Association; and Ian Rolland, chairman of Lincoln National Corp. and the Health Insurance Association of America.



Dr. James Todd

Etheredge is an independent consultant who works with the public and private sectors on health care reforms, income security and government policy issues. He served in the federal Office of Management and Budget (OMB) during four administrations, working on Medicare, Medicaid and national health insurance in the 1970s, and directed the professional health staff of the OMB in both the Carter and Reagan administrations. He is a major architect of the managed competition idea adopted by President Clinton for his health reform proposal. Recently he served as associate director for health reform with the Clinton-Gore transition and as a consultant to the interagency task force developing the reform plan.

Etheredge has been involved in state health policy reforms as a member of the National Governors Association health care task force and the national advisory committee for the Robert Wood Johnson Foundation's state health policy project.

His recent published articles include "Negotiating National Health Insurance," "Managing a Pluralist Health System" and "The Jackson Hole Initiatives for a 21st Century American Health System," written with Paul Ellwood and Alain Enthoven. He is a graduate of Swarthmore College.

Dr. Todd, a general surgeon from Ridgewood, N.J., joined the American Medical Association as senior deputy executive vice president in 1985. Five years later, he was named executive vice president. He was a member of the Board of Trustees from July 1980 to June 1984 and was a commissioner to JCAH from 1982 to 1985.

He has been a director of the Institute of Society, Ethics and the Life Sciences (Hastings Center) and is a member of the Overseers Committee to Visit the Harvard Medical School. He has served as trustee and chairman of the board of trustees of the Medical Society of New Jersey, chairman of the New Jersey delegation to the AMA House of Delegates and chairman of the ad hoc committee to review the AMA's Principles of Medical Ethics. Dr. Todd is a cum laude graduate of Harvard College and Harvard Medical School. He is a diplomate of the American Board of Surgery and a fellow of the American College of Surgeons. ❑

Television news reporter to speak at IMPAC luncheon



Sheilah Kast

Sheilah Kast, an ABC News correspondent, will speak at the convention's annual IMPAC luncheon, set for 1 to 3 p.m. Saturday, Oct. 16. "A View from Washington" is the title of her speech, which will focus on the Clinton health system reform package.

A native of Indianapolis, Kast covers economics and business issues, which have been a focus through most of her reporting career. She covered the Reagan administration from 1985 to 1988, traveling with the President on domestic trips and abroad, such as the historic summit meetings with then-Soviet leader Gorbachev.

She was the first ABC correspondent on the air with news of the attempted coup in Moscow, an issue that she covered for six weeks. She returned to the disintegrating union a few months later to cover the formation of the Commonwealth of Independent States.

Kast's assignment of Congress from 1989 through 1991 included the investigation and resignation of House Speaker Jim Wright, the early votes on the savings and loan bailout and the budget battles between congressional Democrats and President Bush.

Before joining ABC News in 1981, Kast was a financial reporter for *The Washington Star*. She covered the Federal Reserve Board, the Securities and Exchange Commission, other regulatory agencies and energy issues. She switched from newspapers to television when the newspaper folded.

She is a cum laude graduate of the Catholic University of America and lives in College Park, Md.

IMPAC luncheon tickets are $15. ❑

Commercial exhibitors of the 1993 ISMA annual convention

Acordia Health Industry Services, Inc.
AdminaStar
Ameritech
Anthem Health Systems
Continental Medical Systems, Inc.
Emergency Care Physicians
IMACS (Indiana Medical Access and Communication System)
INB National Bank
Indiana Air Guard
Indiana Division of Disability, Aging and Rehabilitative Services
Indiana Pork Producers Association
Eli Lilly and Company/Dista Products Company
Medical Accounts Group
The Medical Laboratory
Medical Protective Company
Miles Pharmaceuticals
Orthopaedics Indianapolis
Physicians Insurance Company of Indiana
P.I.E. Mutual Insurance Company
RANAC Computer Corporation
Rehabilitation Hospital of Indiana
USA Health Professional Support Agency
Whipple & Company

PICI to present loss prevention seminar

Physicians Insurance Company of Indiana will present a Preferred Risk Loss Prevention Seminar as part of the ISMA annual convention. The program will be from 8 to 10 a.m. Saturday, Oct. 16.

The seminar will examine informed consent, including recent case law, current standards and ways to strengthen the process; review problematic clinical scenarios relating to medicine and surgical settings; and discuss the physician/defense counsel relationship.

Presenting the seminar will be Barbara Killila, PICI director of education, risk management; Gene Reiss, PICI director of field services; and Kevin C. Murray, senior PICI defense attorney with Locke Reynolds Boyd & Weisell.

The seminar is designated as a continuing medical education activity for two credit hours in Category I of the Physician Recognition Award of the American Medical Association and is acceptable for two prescribed hours by the American Academy of Family Physicians.

PICI insureds will receive a 5 percent premium discount applied toward their next renewal.

The seminar fee is $50. Advance registration is encouraged and may be made by completing and returning the form in the convention brochure that was sent to all ISMA members. ❑

Dinner to honor outgoing ISMA president

Outgoing ISMA president William H. Beeson, M.D., Indianapolis, will be honored as part of the annual President's Night reception and dinner Saturday, Oct. 16.

The evening will begin with a formal reception from 6 to 7 p.m., followed by dinner and entertainment from 7 to 10 p.m. in the Grand Ballroom.

William C. Van Ness II, M.D., Summitville, will be installed as ISMA president during the dinner.

Five Easy Pieces, whose repertoire ranges from swing to the most current dance hits, will provide the entertainment. The group, which includes two of its original members, is marking its 21st anniversary this year. It performs at such events as corporate functions, private parties, weddings and county fairs and has entertained at the Indianapolis 500 Festival and the Pan-Am games. ❑

ISMA trustee districts





William H. Beeson, M.D., president
Indiana State Medical Association
1992-93

Presidents of ISMA since its organization

Medical Convention	Elected	Served
* Livingston Dunlap, Indianapolis	1849	1849

Medical Society	Elected	Served
* William T.S. Cornett, Versailles	1849	1850
* Ashahel Clapp, New Albany	1850	1851
* George W. Mears, Indianapolis	1851	1852
* Jeremiah H. Brower, Lawrenceburg	1852	1853
* Elizur H. Deming, Lafayette	1853	1854
* Madison J. Bray, Evansville	1854	1855
* William Lomax, Marion	1855	1856
* Daniel Meeker, LaPorte	1856	1857
* Talbot Bullard, Indianapolis	1857	1858
* Nathan Johnson, Cambridge City	1858	1859
* David Hutchinson, Mooresville	1859	1860
* Benjamin S. Woodworth, Fort Wayne	1860	1861
* Theophilus Parvin, Indianapolis	1861	1862
* James F. Hibberd, Richmond	1862	1863
* John Sloan, New Albany	1863	–
* John Moffett (acting), Rushville	1863	1864
* Samuel L. Linton, Columbus	1864	–
* Wilson Lockhart (acting), Danville	1864	1865
* Myron H. Harding, Lawrenceburg	1865	1866
* Vierling Kersey, Richmond	1866	1867
* John S. Bobbs, Indianapolis	1867	1868
* Nathaniel Field, Jeffersonville	1868	1869
* George Sutton, Aurora	1869	1870
* Robert N. Todd, Indianapolis	1870	1871
* Henry P. Ayres, Fort Wayne	1871	1872
* Joel Pennington, Milton	1872	1873
* Isaac Casselberry, Evansville	1873	–
* Wilson Hobbs (acting), Knightstown	1873	1874
* Richard E. Houghton, Richmond	1874	1875
* John H. Helm, Peru	1875	1876
* Samuel S. Boyd, Dublin	1876	1877
* Luther D. Waterman, Indianapolis	1877	1878
* Louis Humphreys, South Bend	1878	–
*Benjamin Newland (acting), Bedford (v.p.)	1878	1879
* Jacob R. Weist, Richmond	1879	1880
* Thomas B. Harvey, Indianapolis	1880	1881
* Marshall Sexton, Rushville	1881	1882
* William H. Bell, Logansport	1882	1883
* Samuel E. Mumford, Princeton	1883	1884
* James H. Woodburn, Indianapolis	1884	1885
* James S. Gregg, Fort Wayne	1885	1886
* Gen. W. H. Kemper, Muncie	1886	1887
* Samuel H. Charlton, Seymour	1887	1888
* William H. Wishard, Indianapolis	1888	1889
* James D. Gatch, Lawrenceburg	1889	1890
* Gonsolvo C. Smythe, Greencastle	1890	1891
* Edwin Walker, Evansville	1891	1892
* George F. Beasley, Lafayette	1892	1893
* Charles A. Daugherty, South Bend	1893	1894
* Elijah S. Elder, Indianapolis	1894	–
* Charles S. Bond (acting), Indianapolis	1894	1895
* Miles F. Porter, Fort Wayne	1895	1896
* James H. Ford, Wabash	1896	1897
* William N. Wishard, Indianapolis	1897	1898
* John C. Sexton, Rushville	1898	1899
* Walker Schell, Terre Haute	1899	1900
* George W. McCaskey, Fort Wayne	1900	1901
* Alembert W. Brayton, Indianapolis	1901	1902
* John B. Berteling, South Bend	1902	1903
* Jonas Stewart, Anderson	1903	1904
* George T. MacCoy, Columbus	1904	1905
* George H. Grant, Richmond	1905	1906
* George J. Cook, Indianapolis	1906	1907
* David C. Peyton, Jeffersonville	1907	1908
* George D. Kahlo, French Lick	1908	1909
* Thomas C. Kennedy, Shelbyville	1909	1910
* Frederick C. Heath, Indianapolis	1910	1911
* William F. Howat, Hammond	1911	1912
* A. C. Kimberlin, Indianapolis	1912	1913
* John P. Salb, Jasper	1913	1914
* Frank B. Wynn, Indianapolis	1914	1915
* George F. Keiper, Lafayette	1915	1916
* John H. Oliver, Indianapolis	1916	1917
* Joseph Rilus Eastman, Indianapolis	1917	1918
* William H. Stemm, North Vernon	1918	1919
* Charles H. McCully, Logansport	1919	1920
* David Ross, Indianapolis	1920	1921
* William R. Davidson, Evansville	1921	1922
* Charles H. Good, Huntington	1922	1923
* Samuel E. Earp, Indianapolis	1923	1924
* Eldridge M. Shanklin, Hammond	1924	1925

Medical Association	Elected	Served
* Charles N. Combs, Terre Haute	1925	1926
* Frank W. Cregor, Indianapolis	1926	1927
* George R. Daniels, Marion	1926	1928
* Charles E. Gillespie, Seymour	1927	1929
* Angus C. McDonald, Warsaw	1928	1930
* Alois B. Graham, Indianapolis	1929	1931
* Franklin S. Crockett, Lafayette	1930	1932
* Joseph H. Weinstein, Terre Haute	1931	1933
* Everett E. Padgett, Indianapolis	1932	1934
* Walter J. Leach, New Albany	1933	1935
* Roscoe L. Sensenich, South Bend	1934	1936
* Edmund D. Clark, Indianapolis	1935	1937
* Herman M. Baker, Evansville	1936	1938
* Edmund M. Van Buskirk, Fort Wayne	1937	1939
* Karl R. Ruddell, Indianapolis	1938	1940
* Albert M. Mitchell, Terre Haute	1939	1941
* Maynard A. Austin, Anderson	1940	1942
* Carl H. McCaskey, Indianapolis	1941	1943
* Jacob T. Oliphant, Farmersburg	1942	1944
* Nelson K. Forster, Hammond	1943	1945
* Jesse E. Ferrell, Fortville	1944	1946
* Floyd T. Romberger, Lafayette	1945	1947
* Cleon A. Nafe, Indianapolis	1946	1948
* Augustus P. Hauss, New Albany	1947	1949
* C. S. Black, Warren	1948	1950
* Alfred Ellison, South Bend	1949	1951
* J. William Wright, Indianapolis	1950	1952
* Paul D. Crimm, Evansville	1951	1953
* William Harry Howard, Hammond	1952	1954
* Walter L. Portteus, Franklin	1953	1955
* Walter U. Kennedy, New Castle	1954	1956
* Elton R. Clarke, Kokomo	1955	1957
* M. C. Topping, Terre Haute	1956	1958
* Kenneth L. Olson, South Bend	1957	1959
* Earl W. Mericle, Indianapolis	1958	1960
* Guy A. Owsley, Hartford City	1959	1961
* Harry R. Stimson, Gary	1960	1962
* Maurice E. Glock, Fort Wayne	1961	1963
* Donald E. Wood, Indianapolis	1962	1964
Joseph M. Black, Seymour	1963	1965
* Kenneth O. Neumann, Lafayette	1964	1966
* Eugene S. Rifner, Van Buren	1965	1967
* G. O. Larson, LaPorte	1966	1968
Patrick J. V. Corcoran, Evansville	1967	1969
Lowell H. Steen, Hammond	1968	1970
* Malcolm O. Scamahorn, Pittsboro	1969	1971
Peter R. Petrich, Attica	1970	1972
* James H. Gosman, Indianapolis	1971	1973
Joe Dukes, Dugger	1972	1974
Gilbert M. Wilhelmus, Evansville	1973	1975
Vincent J. Santare, Munster	1974	1976
* John W. Beeler, Indianapolis	1975	1977
* Eli Goodman, Charlestown	1976	1978
* James A. Harshman, Kokomo	1977	1978
* Arvine G. Popplewell, Indianapolis	1978	1979-80
Alvin J. Haley, Carmel	1979	1981
* Martin J. O'Neill, Valparaiso	1980	1982
John A. Knote, Lafayette	1981	1983
George T. Lukemeyer, Indianapolis	1982	1984
Lawrence E. Allen, Anderson	1983	1985
Paul Siebenmorgen, Terre Haute	1984	1986
Shirley Thompson Khalouf, Marion	1985	1987
John D. MacDougall, Beech Grove	1986	1988
Fred W. Dahling, New Haven	1987	1989
George H. Rawls, Indianapolis	1988	1990
Michael O. Mellinger, LaGrange	1989	1991
C. Dyke Egnatz, Schererville	1990	1992
William H. Beeson, Indianapolis	1991	1993

* **Deceased**

annual reports

Editor's note: The annual reports that were not submitted in time to be included in this issue will be printed in the January 1994 issue of INDIANA MEDICINE.

EXECUTIVE COMMITTEE
William H. Beeson, M.D., president

The most pressing issue during the past 12 months has been health system reform and the impact it would have on physicians, patients and the practice of medicine. The State Health Policy Commission culminated its three years of deliberation by releasing its final report in late November. The report was a comprehensive document addressing multiple facets of health system reform with an executive summary with more than 200 pages. This abstruse document set the stage for an active debate on health system reform to take place during the 1993 legislative period. This, combined with significant cost overruns in the state Medicaid program, coupled with the formation of President Clinton's Health Reform Task Force, placed medical issues at center stage during the recent legislative session.

In October 1992, ISMA task forces were formed to address the issues of health system reform, Medicaid, ISMA-PICI relations and preventive health. Each of those task forces has been active during the past 12 months, and their activities have been closely monitored by the Executive Committee. Comprehensive written summary reports of those task forces will be available at the annual convention.

Your Executive Committee met in weekly telephone conference calls throughout the legislative session to monitor our lobbying activities and efforts. While more detailed information regarding the legislative session can be obtained by review of the Commission on Legislation report, these activities played such a prominent position in Executive Committee activities that they warrant a review.

Off-label drug legislation and drug labeling legislation, which requires drug labels to include the brand name when generic substitution is made, were both enacted. Action was also taken to define "surgery" to include the medical use of lasers. Each of those were supported by the ISMA, the latter two being initiated by prior House of Delegates resolutions.

What perhaps is even more important to point out is the fact that ISMA successfully lobbied against several pieces of legislation that would have proven detrimental to medicine – sick taxes, restrictions on physician self-referral, the triplicate prescription program and price controls. In addition, ISMA was successful in maintaining the "any willing provider" language for PPO programs.

Our continued contact with media and opinion makers as well as legislators was worthwhile. We authorized production of a videotape and audiocassette explaining the Indiana Compensation Act for Patients to legislators. This was reviewed and monitored by the Executive Committee. It is noteworthy to point out that there were no changes in our medical malpractice law during this session.

On the business side, the Executive Committee evaluated the ISMA investments and developed a comprehensive and effective method to monitor our investments and to maximize our return on investments. Up to 20% of investments will be placed in no-load mutual funds.

Staff monitoring revealed financial irregularities that were subsequently confirmed by our annual audit. This resulted in legal action being taken against a former employee and a comprehensive review of our financial system and monitoring protocols. Insurance coverage has eliminated any adverse financial impact on the ISMA for these activities. The Executive Committee has fully reviewed our financial management system and decided that it is appropriate to preserve the financial integrity of the organization and to prevent subsequent unauthorized access of funds.

Thorough evaluation of our insurance coverage and current Indiana law, along with ISMA bylaws, indicated that specific language was needed to address the issues of indemnification for officers and others acting on behalf of the ISMA. The Executive Committee developed, through staff and in concurrence with the Board of Trustees, a resolution to be submitted to the 1993 House of Delegates addressing indemnification of officers and directors.

Administrative functions were analyzed, and a local area network computer system was installed and expanded to bring ISMA computer operations into the 21st century. This also will allow expanded capabilities and more effective and timely communications with officers, trustees and county medical societies.

Forced to choose between replacing an engine on our current aircraft or replacing it altogether, we chose to replace our plane with a newer model, which would provide the ISMA with greater leasing opportunities to

offset aircraft operating expenses. The Executive Committee directed ISMA staff to fully evaluate various proposals, which were presented to the Board of Trustees for its review. The Board of Trustees approved the purchase of a used MU-2 aircraft in May. The Executive Committee will continue to evaluate the feasibility of the aircraft and monitor financial operations with periodic reports to the Board of Trustees. It is hoped that increased leasing opportunities will provide expanded revenues to the association and further decrease operational costs.

The Executive Committee accepted a $50,000 contribution from the Indiana Hospital Association on behalf of the Commission on Physician Assistance. This contribution is for a two-year period and will help defray commission expenses. The Executive Committee continues to review with staff commission operations and continues to explore additional revenue sources to support current and expanded operations for the commission.

The Executive Committee felt it imperative that ISMA be proactive regarding health reform and that ISMA members be kept abreast of the changing health care environment. Approval was given for development of a speaker training program to provide media and opinion makers with the physician perspective on health reform.

The Executive Committee wishes to extend its compliments to the ISMA staff for an admirable job in carrying out the expanded activities of the association in a professional, timely and fiscally responsible manner. Excellent administrative and financial management by ISMA staff allowed us to address the strategic concerns of the association and yet remain under budget for the fiscal year.

BOARD OF TRUSTEES
Jerome Melchior, M.D., chairman

Without a doubt, 1993 has been the most politically active year I have noted in the past decade of my involvement with the ISMA. We have won some clearcut political victories for our colleagues and, most importantly, for our patients.

Due to the farsighted approach of Rick King, ISMA executive director, and the ISMA staff, there was no significant legislative threat to the Indiana Compensation Act for Patients this year. Our media campaign to educate Hoosiers concerning their unique malpractice law, with its protections for injured patients, was successful. As of this writing, the special legislative session is still in progress, and the mandated triplicate prescription bill has been defeated twice. By defeating this bill, physicians will be able to spend more time actively caring for patients rather than completing bureaucratic paperwork.

Many problems still remain. The health systems reform bill is still alive, and it appears that some of the recommendations will be included in the Medicaid reform presently being debated. As of today, none of this has been funded, and it still remains the main problem of the special legislative session.

Last January, there was strong talk in the General Assembly about a possible physician provider tax. This "sick tax" was not included in any legislation due to strong opposition by the ISMA.

These multiple accomplishments have occurred because of ISMA interaction and grassroots physicians. This combination is unbeatable when ISMA leadership informs you of legislation that will adversely affect your patients' care, and you respond with phone calls and letters to legislators trying to educate them and encourage them to vote for our patients' welfare. These grassroots efforts have worked well this year, and they need to continue.

Congratulations to all who participated this year. Your patients will benefit from your involvement.

AMA DELEGATION
Marvin E. Priddy, M.D., chairman

I would like to thank the members of our delegation for their dedication and effort in maintaining Indiana's active role at the AMA House of Delegate meetings:

Delegates
John Knote, M.D., Lafayette
Ed Langston M.D., Indianapolis
George Lukemeyer, M.D., Indianapolis
John MacDougall, M.D., Beech Grove
Shirley Khalouf, M.D., Marion

Alternates
Alfred Cox, M.D., South Bend
Max Hoffman, M.D., Covington
Mike Mellinger, M.D., LaGrange
George Rawls, M.D., Indianapolis
John Thomas, M.D., Fort Wayne

Interim Meeting
The AMA House of Delegates met Dec. 6-9, 1992, in Nashville with 436 credentialed delegates representing 54 states and territories, 83 national medical specialty societ-

ies, five special sections and five government services.

The delegates considered 90 reports and 231 resolutions. Health system reform, managed care, managed competition, negotiations, global budgeting and refinements to AMA's Health Access America dominated the time and attention of the delegates.

At the direction of the ISMA House of Delegates, the Indiana delegation introduced three resolutions: 107, 213 and 809. Resolution 107, dealing with reimbursement and the AMA House of Delegates, reaffirmed current AMA policy in lieu of the resolution. Resolution 213, concerning competitive physician salaries, was not adopted. Resolution 809, related to mandatory computerization of patient records, was amended, and the House adopted the following substitute resolution: "Resolved, that the American Medical Association strongly urge third-party payors and others to preserve the option of the non-computerized medical records, with no disincentives and no punitive measures for those physicians who continue to use non-computerized medical records."

Regarding organized medicine's role in health care policy development and implementation, the House amended and adopted the following recommendations:

- That the AMA continue its aggressive leadership campaign for antitrust relief and legal and legislative recognition of physicians' right to negotiate.
- At a time of the potential for imminent health system reform, the House of Delegates empower the Board of Trustees to act on behalf of the Association to promote proactively and negotiate for those elements of health system reform that they feel will best represent the interests of patients and the profession.

Annual Meeting

The 1993 Annual Meeting was held June 13-17 in Chicago with 435 voting delegates and 117 reports and 229 resolutions for consideration.

First Lady Hillary Rodham Clinton addressed the opening session of the House of Delegates, garnering approval from the audience as she spoke to many of the major concerns of physicians, including CLIA regulations, third party interference, professional liability reform and quality of care.

Major issues considered at the meeting included harnessing market forces in medical pricing, health system reform, required benefits packages, sexual orientation discrimination, repeal of CLIA, enterprise liability, increasing the availability of primary care, National Practitioner Data Bank, AMA dues and AMA's National Campaign Against Family Violence.

The House elected Robert McAfee, M.D., president-elect; Daniel Johnson Jr., M.D., speaker of the house; and Richard Corlin, M.D., vice speaker. John Knote, M.D., was re-elected to his second term on the AMA Council on Medical Service. Indiana also continues to be represented on the AMA Council on Medical Education by George Lukemeyer, M.D.

During the 1992 ISMA annual convention, two long-time dedicated members, Alvin Haley, M.D., Indianapolis, delegate, and Herbert Khalouf, M.D., Marion, delegate, retired from the delegation. Shirley Khalouf, M.D., Marion, and Ed Langston, M.D., Indianapolis, were elected to fill the delegate positions, and the ISMA House elected John Thomas, M.D., Fort Wayne, and Alfred Cox, M.D., South Bend, to fill the two alternate delegate vacancies. Thanks to Drs. Haley and Khalouf for their loyalty in representing Indiana in the AMA House of Delegates. With regret, the delegation accepted a letter of resignation from Delegate Ed Langston, M.D., Indianapolis. His service and efforts on behalf of the delegation are appreciated. A replacement delegate will be elected at the 1993 ISMA annual convention.

We were saddened in January by the death of our colleague, Herbert Khalouf, M.D. He will be missed by the delegation and the Indiana State Medical Association.

The entire delegation works diligently at each AMA meeting to voice the "Indiana perspective" on vital issues affecting the Hoosier physician and the delivery of health care in the state. If you can't attend the meetings, you can still be assured that you are represented through your delegation. Let us know your opinions!

RESIDENT MEDICAL SOCIETY

Ruchir Sehra, M.D., trustee

This year, ISMA-RMS has remained active at both state and national levels. Nationally, we have continued to be well-represented at the AMA Resident Physician Section interim meeting in 1992 and annual meeting in 1993. Our national delegation consists of many new members with most delegates in their first two years of residency training. A new Great Lakes Section was formed at the 1993 meeting in which the

Indiana delegation has been actively involved from the start. Some members attended the National Leadership Conference in Atlanta and the Washington Summit last spring. As our membership matures, we hope to be even more active and vocal nationally.

On the state level, the ISMA-RMS continues to work closely with the Medical Student Section to foster continued participation as students become residents. Medical student leaders who have stayed in Indiana for residencies have continued to take an active role at the resident level. We are also trying to simplify the ISMA dues system for residents to prevent a lag in receiving benefits and make membership more economically palatable.

This past year was a rebuilding year because many of our senior members graduated from their residency training programs. With an influx of younger members, much of this year was spent learning about the ISMA and AMA-RPS. We have modified our constitution to better reflect current membership practices and goals. Our governing council has been reorganized to encourage more participation. We look forward to increasing participation and activity next year.

Thank you to the ISMA for its continued support of resident activities in Indiana.

MEDICAL STUDENT SOCIETY
Scott Hollingsworth, trustee

It has been a privilege to represent the Medical Student Society this year. It has been a busy and productive year for the students. The student society concentrated on the following items:

As always, we had strong representation at the interim and annual meetings and, for the first time, we sent a large delegation to the National Leadership Conference. In the past, we have only been able to send a few people to the leadership conference, but the intensive educational nature of the conference has been able to create so much enthusiasm that we hope to send a group every year.

We emphasized recruitment last fall, especially on the Indianapolis campus. We had a party at the Marriott where we signed up new members and introduced students to the AMA. At this party and several other times on campus, we set up a table and registered students to vote. The MSS registered about 200 people to vote in the November election.

The student society sponsored an AMA-MSS section meeting. The topic for the meeting was "Health System Reform and the 1992 Election," and John Knote, M.D., was one of the speakers. The conference was well attended with about 50 students representing Indiana, Illinois, Ohio, Michigan and Kentucky.

Once again, we sponsored the "Student-to-Student" program on the Northwest and Bloomington campuses. The program sends medical students to primary and secondary schools to speak about health-related subjects (smoking, drugs, alcohol, AIDS, etc.). The program was tremendously successful on both campuses.

This spring, Sharon Swan, AMA political analyst, spoke at one of our meetings about "Student Leadership Opportunities in the AMA-MSS." We hope to see Indiana students in national leadership positions.

We are working on a project to create canvas artwork for the walls of the Regenstrief Outpatient Pediatric Clinic. It has taken several months to organize the project, but it will come to fruition.

All of the students thank the ISMA for its support. Rosanna Iler, ISMA, has been extremely helpful and her work and knowledge are appreciated. The members of the MSS are limited to four years of involvement (thank goodness medical school isn't longer), and Rosanna contributes continuity and perspective to our group. We are looking forward to another year of growth.

PHYSICIANS INSURANCE COMPANY OF INDIANA
M. David Duncan, PICI president and CEO

Members of the ISMA leadership and the PICI Board of Directors chose to commemorate the beginning of the company's second decade of leadership in 1993 rather than its 10th anniversary, for specific reasons.

Challenges Indiana physicians will face during the coming decade are likely to be far more formidable than in 1982, when the ISMA formed PICI to give Indiana physicians a strong voice in professional liability protection.

To meet the challenges of the 1980s, PICI brought to Indiana physicians coverage and service features not previously available: requirement of the insured's consent to settle a claim; premium discounts for risk management programs; loss-free credits; a young physicians program; a comprehensive package plan for medical groups and corporations; and vigorous opposition to frivolous claims.

Most importantly, PICI involved physicians in the forma-

tion of operating goals and philosophies and in the conduct of operations. And, PICI joined forces with the ISMA to successfully defeat proposals that would have weakened and altered Indiana's Compensation Act for Patients.

PICI established a dominant marketing role and a strong fiscal position against aggressive competition from other, often larger, insurers. Several competitors entered Indiana with sharply underpriced coverage, only to cease operations later. PICI is well-entrenched as the leading protector of Indiana physicians, with a long-term commitment.

During the 1990s, PICI is prepared to continue demonstrating responsiveness, efficiency and innovation. Through a combination of products, services and advancing technology that maximizes the capabilities of management and staff, PICI will continue creating value to policyholders. PICI's concept of value is evidenced by its "dedicated team" approach to claims services. The PICI defense team includes an Indianapolis-based staff of experienced defense attorneys and legal assistants whose sole responsibility and activity is legal litigation services for PICI insured. The team also embraces a Claims Committee that the board composed entirely of Indiana physicians, a skillful internal claims staff and local attorneys who add local perspective and knowledge.

PICI also is prepared to respond to the impact on professional liability of new and expanding alliances within the health care industry. Physicians, hospitals, diagnostic and outpatient centers, dentists and other health care professionals and entities are linked through participation in large point-of-service, preferred provider organizations and other forms of managed care plans. Parties involved in health care are being pressured to share resources and band together in advanced electronic systems that reduce paperwork, increase efficiency and lower costs. PICI's Woodfield Group, formed to provide claims administration and other management services to health care entities that choose to partially or fully self-insure, is well-positioned to take advantage of emerging opportunities related to these trends and developments.

Most importantly, PICI is prepared for the great challenges that will arise from anticipated federal health care reform legislation. Many, if not most of the reform concepts under consideration would require an extended period of time for full-scale implementation and probable refinements. Although the shape of federal health care reform remains unclear, the delivery of health care already is being changed by other forces and factors, including the rapid growth of managed care, ongoing medical advancements and reforms initiated in several states.

Now and in the future, it is absolutely essential for Indiana's private physicians, their corporate entities and staff members and health care colleagues to demand high-quality protection that accurately reflects their best interests and needs. Coverage and service methodologies must recognize and resolve any new, arising liability issues, as well as the complexities of a health care system in transition.

PICI's ability to respond positively to these and other challenges during its second decade of leadership is heightened greatly by its relationship with the ISMA and the direct participation of Indiana physicians in its operations. PICI and the ISMA, working together, will continue to make the difference in professional liability protection.

SECOND DISTRICT
Jerome Melchior, M.D., trustee

It has been a pleasure to serve you as trustee for the Second District during 1993. I have detailed many of the organization's accomplishments in the Board of Trustees report.

The Second District had its annual meeting in May, and I was re-elected to serve as your trustee. I wish to thank all physicians in our district who responded to the many calls for action on specific legislative problems this year. It is you, the grassroots physicians, who have the best chance of educating legislators. Your involvement is mandatory since it is the legislators who regulate, in many instances, the type and quality of care your patients may receive.

As your trustee, I specifically wish to thank the ISMA staff and ISMA Field Staff Representative Janna Kosinski. It is their invaluable assistance that allows us to be active at the state level while still maintaining full-time practices.

THIRD DISTRICT
Gordon L. Gutmann, M.D., Joseph M. Casey Sr., M.D., and James A. Westervelt, M.D., trustees

The Third District held its annual meeting at the Corydon Country Club. Although attendance was small, the discussion was lively.

The program included a two-way audio hook up with Rep. Lee Hamilton in Washington, D.C.

Discussion mostly centered on Hillary Rodham Clinton's health care reform task force. Apparently, Rep. Hamilton did not know any more than we did and that was what he read in the papers. He reassured us that before any health care reform could take place, legislation would have to pass through numerous committees on its way through the legislative process. He assured us that he would be vigilant and represent our best interest and the interest of his constituents as these policies are formulated. Questions asked by members of the audience no doubt enlightened Rep. Hamilton that there were many difficult situations and unanswered problems with health care reform.

ISMA President William Beeson, M.D., gave an impassioned plea for participation by physicians in the legislative process and communication with both state and national representatives on health care matters. Since there were no trustees elections, the meeting was adjourned after dinner. Participation in Third District medical matters continues to be by a few interested individuals.

Our ISMA Field Representative, Janna Kosinski, has done an excellent job in conveying information from the state level to the local level. Due to time constraints, I have not been able to visit the component societies as often as I would have liked.

FOURTH DISTRICT
Arthur C. Jay, M.D., trustee

The Fourth District quarterly meetings were well-attended by its members. Discussions centered around items of vital interest including health care reform issues, the ongoing controversy with Medicaid, especially the provider tax. There was discussion concerning the shortage of physicians in some areas and how to recruit physicians effectively. The issue of managed care also was discussed and how to participate in that and/or compete against the large managed care HMOs already in existence.

Bill Cooper, M.D., is president-elect and is the speaker of the House of Delegates. The Fourth District expressed their full support behind Dr. Cooper. The Fourth District president is Barbara Taylor, M.D., Greensburg, and the secretary is Angie Fontanilla, Greensburg. President-elect is Noshir Toddywalla, M.D., from Dearborn County.

The annual meeting was held at the Batesville Country Club and attended by 19 district members. A total of 26 members, including officers and staff, made the meeting an active and worthwhile event with good discussions.

We sincerely appreciate the help of the ISMA Executive Director Rick King and Janna Kosinski, ISMA field staff representative, for their help and information during this active year. We look forward to next year and hope for the future.

SEVENTH DISTRICT
Bernard J. Emkes, M.D., John L. Records, M.D., and Ronald Stegemoller, M.D., trustees

Membership continues to grow in the Seventh District. This year, the decision to unite with organized medicine will be crucial, so all Seventh District members are encouraged to invite their nonmember colleagues to join our organization.

Several members of the Seventh District have continued their political activities by serving as Doctor of the Day during the legislature, a program co-sponsored by the Indiana Academy of Family Physicians and the ISMA. Many members also traveled to Washington, D.C., and in March, several members attended the AMA's Washington Summit and lobbied many Congressmen and senators.

In keeping with our theme to provide annual meetings for the entire family, The Children's Museum provided an ideal setting for the young and young at heart. Seventh District President Ronald K. Stegemoller, M.D., welcomed the record crowd and conducted the business meeting in conjunction with the dinner to provide information and updates to the spouses.

During the business meeting, ISMA President and Seventh District member William H. Beeson, M.D., urged physicians to become more politically astute this year and, thereby, continue the momentum of this year's successful legislative season.

The Seventh District has been well-represented by Dr. Beeson and Peter L. Winters, M.D., vice speaker of the House of Delegates. We greatly appreciate and acknowledge their diligence in car-

rying out their important responsibilities.

We conclude our report with results of this year's elections: Craig A. Moorman, M.D., Johnson County, was elected president-elect; John F. Schneider, M.D., Marion County, was elected secretary-treasurer; John L. Records, M.D., Johnson County, was elected trustee; and G. Lal Ahuja, M.D., Indianapolis, was elected alternate trustee.

Following the annual meeting, Paula Hall, M.D., of Morgan County began her year as president. She will be an excellent representative for our members next year.

We congratulate all of our newly elected and re-elected officers and appreciate their willingness to serve as leaders of the Seventh District!

EIGHTH DISTRICT
John V. Osborne, M.D., trustee

The Eighth District met throughout the year to prepare for the ISMA annual convention and Eighth District Annual Meeting. The annual district meeting was held June 2 at the Delaware Country Club. The meeting was called to order by Gordon Hughes, M.D., president, and the 1992 minutes were accepted.

Susan Pyle, M.D., of Union City, was elected president unanimously, and Jerome Leahey, M.D., was elected secretary. John Osborne, M.D., of Muncie was re-elected trustee for a three-year term.

Old business was discussed, and everyone complimented the way the pharmaceutical displays were handled and presented.

Before dinner, three speakers were introduced, and a panel discussion on "Medicine in Transition" was held. The speakers were William Beeson, M.D., ISMA president; Davis Ellis, M.D., medical director of the Indiana Medicaid Program; and Rep. Bruce Munson, district 35. Dr. Beeson presented the ISMA's plan to help the Medicaid crisis, and Dr. Ellis said the crisis was by virtue of socio-economics because the practice of medicine was becoming more fragmented. Rep. Munson voiced his concern about Indiana's high ranking in Medicaid costs. He believes Medicaid recipients should perform services for the state in return for receipt of these funds. After dinner, Steve Hart performed magic tricks.

NINTH DISTRICT
Stephen D. Tharp, M.D., trustee

Once again, the Ninth District continues to remain active in serving our members. On June 9, the annual meeting was held at Governor Noble's Eating Establishment on the grounds of Conner Prairie. The meeting was hosted by the Hamilton County Medical Society with Thomas Mabel, M.D., acting as Ninth District president.

It seems this year more than ever, everyone was deeply concerned about the political climate and our continued ability to practice medicine, giving quality cost-effective care to our patients. Our meeting was highlighted by remarks from William Beeson, M.D., ISMA president, who updated us on the many rapid political changes occurring, especially with the positioning of the legislature during the special session.

Fortunately, with the direction of its membership and the enthusiasm of your officers, the ISMA has become a very effective agent in promoting the health and well-being of the citizens of Indiana. We should all be proud of the work the ISMA has done to protect health care consumers from excessive cost and taxation while continuing to provide quality health care. The quality of that health care was made particularly conspicuous as we were entertained by "Dr. Campbell" of Conner Prairie, who recounted his experiences as a working physician in the mid-19th century.

We are looking forward to the challenges facing us in the future. It is with great enthusiasm that I report that your ISMA leaders are dedicated and capable of guiding us through the changes we are likely to face. It has been a privilege to serve you this year, and I look forward to continuing our efforts together.

TENTH DISTRICT
Frank M. Sturdevant, M.D., trustee

This is the end of my first year as trustee for the 10th District, and I feel that it was a success. This year, our major concerns were legislative, and we are gratified to find that INCAP was not invaded and that no new legislation was passed that would harm the practice of medicine in Indiana.

I want to thank my alternate trustee, Thomas Brubaker, M.D., and all the members of 10th District who traveled to Indianapolis to meet with legislators and ISMA leaders.

Our annual meeting was held in June. During the meeting, the Task Force of Northwest Indiana presented its plans to stimulate the economy in northwest Indiana. Mr. "Catfish" Hunter also spoke at the meeting. Visits from

ISMA President William Beeson, M.D., and ISMA Chairman of the Board Jerome Melchior, M.D., and their legislative updates were much appreciated.

I want to congratulate Dr. Lopez on a job well done as district president and look forward to working with John Swarner, M.D., the new president. District members hope to accumulate enough members to make the 10th District a two-trustee district.

The overriding concern among district members continues to be the unequal contribution to the Patients Compensation Fund by the members of Lake County. We are glad to hear there is some movement again in this area and watch for a future balance of contributions to the PCF.

ELEVENTH DISTRICT
Jack W. Higgins, M.D., trustee

The 1992 annual meeting was held at the Meshingomeshia Country Club in Marion and was hosted by the Grant County Medical Society. ISMA leadership was well represented at the meeting. John King, M.D., from the AMA presented an update on AMA activities. Larry Musselman, M.D., was re-elected alternate trustee. All of the candidates for the Indiana legislature from the 11th district were invited and five attended. It is very important that we continue to invite state legislators and candidates to future meetings. It is a great opportunity to express our views to those legislatures and candidates that attend.

The dinner meeting was well attended and included an outstanding panel discussion on "Euthanasia and Physician Assisted Suicide." Regie Urgena, M.D., who organized the meeting, did an outstanding job. Dr. Urgena also assigned local physicians to host ISMA leaders and legislators, which facilitated better interaction between the physicians and guests. I would suggest that the local hosts continue the practice. My thanks and congratulations to Dr. Urgena.

District leaders attended a quarterly meeting in February to discuss legislative issues and plan the 1993 meeting, which will be hosted by the Carroll County Medical Society in September. Members from Grant, Cass, Miami and Howard counties were present. Future county leaders should attend the meetings. We will have to be informed to survive the hostile environment in the future. Fee-for-service medicine is under attack, and we must participate in organized medicine to protect the best medical system in the world.

It was a long arduous legislature this year, as you already know. The ISMA legislative staff did an outstanding job lobbying and informing ISMA leaders. The list of specific issues is too long to address in this report, but the most important include no significant changes in INCAP, no hospital or physician provider taxes, repeal of the triplicate prescription program, no price controls for health services and the "any willing provider" law was continued.

I would like to thank all of the members who called or wrote to their state legislators during this session. I think the grassroots efforts during this legislative session were the most active and effective since 1974 when INCAP was enacted. We must continue to be politically active. Please participate in the ISMA Key Contact program. If you are not participating, call the ISMA Legislative Department, Larry Musselman, M.D., or me, and we will include you in the program.

I would like to thank you for allowing me to represent you at ISMA board meetings. If you have any questions or concerns, contact me or Dr. Musselman, and we will do our best to satisfy your concerns.

TWELFTH DISTRICT
John Thomas, M.D., trustee

This year has been marked by a resurgence in interest by physicians in our district in becoming more actively involved in shaping the political process. Whatever the reasons, our legislators have been lobbied like never before by our members, and they have responded with favorable votes after receiving our informative calls and letters. I would like to thank every member of this district for their efforts this year.

Our annual meeting was held at the Fort Wayne Country Club. The meeting included a golf outing, a business meeting, dinner and a speaker.

Our new alternate trustee, Joe Mantheiy, M.D., has done an outstanding job, and I want to thank him for all his help. Rick Ryan, ISMA field representative, continues to carry the word to all corners of the district, and we appreciate everything he does for us.

COMMISSION ON CONSTITUTION & BYLAWS
Fred W. Dahling, M.D., chairman

The updated and revised bylaws to the ISMA Constitution & Bylaws, appearing in the delegate's handbook and in INDIANA MEDICINE,

constitute the annual report of the Commission on Constitution & Bylaws.

No other business was transacted, and no formal meetings of the committee were required.

COMMISSION ON LEGISLATION

Michael O. Mellinger, M.D., chairman

As chairman of the Commission on Legislation, I want to congratulate all ISMA members for your involvement this year. Never was there a legislative session where we, as physicians, (and our patients) had so much to lose.

Health care reform was, and still is, a central legislative issue. Everyone involved seemed to have an answer. The governor's Health Policy Commission, the Indiana Trial Lawyers Association, the insurance industry, and even the Indiana Manufacturers Association (in an unexpected alliance with organized labor), all of these groups, and more, had solutions. The resulting situation was even more chaotic than the usual legislative session.

We received strong leadership from ISMA President William Beeson, M.D.; Rick King, ISMA executive director; and the ISMA Executive Committee. Mike Abrams, ISMA director of marketing and government relations, and the ISMA Government Relations Department did their usual excellent job of transmitting our ideas and philosophy to the legislators. However, the most important factor was the grassroots involvement of the ISMA membership. The effectiveness of the legislative contacts generated by the "telephone tree" and other communications can only be achieved by individual physicians communicating with their own legislators.

Of the more than 1,500 bills introduced, the ISMA identified nearly 300 that involved health care. Several good pieces of legislation failed to become law. Most of the bills that impacted health care were in need of being defeated. Overall, the ISMA had a successful session.

How successful were we? Perhaps this question can be answered only when we can put this session in context with others, past and future. The unfortunate split between the legislative and executive branch has left somewhat of a void. One thing is certain: A void never remains that way.

The financing of health care will continue, as it always has, to respond to changing conditions. We at the ISMA need to be in the strongest possible position to see that our patients are not shortchanged in the process.

The following is a summary of the more important recently passed health care laws of interest to physicians:

HEA 1234 – Requires a pharmacist to place the following statement on the label of each generic drug prescription: "_____ Generic for _____ " with the generic and brand names inserted on the blank lines.

HEA 1564 – Allows the state board of nursing, in conjunction with the medical licensing board, to establish rules regarding the appropriate use of legend drugs by nurses in advanced practice.

SEA 233 – Allows a physician to supervise two physician assistants.

SEA 386 – Updates the definition of surgery to includes lasers and ionizing radiation.

The following list highlights some of the bills that failed to pass the 1993 session:

SB 189 – Sought to grant civil immunity written by a physician for a prescription written by an optometrist.

SB 431 – Would have eliminated the any willing provider protections in current health insurance law.

SB 505 – Would have required the Medicaid agency to pay all claims within 30 days of submission. If the claim is denied, the agency would have been required to give the provider a clear and concise reason for the denial. The bill also would have established a tuition abatement program for medical students who agree to practice primary care in a medically underserved area.

SB 636 – Would have prohibited corporal punishment in public schools.

HB 1053 – Would have allowed a person to indicate in a living will whether to withhold or withdraw artificial nutrition and hydration.

HB 1182 – Sought to prohibit physician self-referral.

HB 1341 – Would have allowed a physical therapist direct access to treat patients.

HB 1455 – Would have allowed the worker's compensation board to adopt fee schedules for certain medical services.

HB 1537 – Sought to prevent county hospitals from discriminating against any licensed practitioner, chiropractor, podiatrist, dentist, etc., who desires privileges to practice within the scope of their license within the facility.

HB 1675 – Sought to indefinitely extend the triplicate prescription program.

There was also a program forwarded by representatives of organized labor and the Indiana

Manufacturers Association that would have imposed price controls on medical services. This proposal was never inserted into legislation because of the overwhelming opposition expressed by ISMA members.

The ISMA staff has published the *1993 Digest of Health and Medical Laws* that, in greater detail, highlights the newly created health care laws. To receive a copy, call the ISMA Department of Government Relations at (317) 261-2060 or 1-800-257-4762.

The Commission on Legislation met four times during the legislative session to review pending legislative proposals and their impact on physicians in the state. The final commission meeting was held in conjunction with a Board of Trustees meeting, where members then visited the Statehouse and discussed important issues of the day with members of the General Assembly.

I want to personally thank the members of the commission for their time and effort. Their commitment and service to the ISMA are much appreciated.

COMMISSION ON MEDICAL EDUCATION
James E. Carter, M.D., chairman

The Commission on Medical Education and the Subcommission on Accreditation met Nov. 15, 1992, and April 18, 1993. Stephen Jay, M.D., is chairman of the Subcommission on Accreditation, and Donald Dian, M.D., is vice chairman of the Subcommission on Accreditation. Glenn Bingle, M.D., is vice chairman of the Commission on Medical Education and chairman of the Subcommission on Physician Remedial Education.

The ISMA Accreditation Program for Continuing Medical Education was awarded continued recognition for four years. This is now the maximum recognition period awarded by the CRR of the ACCME.

During the year, 15 institutions and organizations were approved by the Commission on Medical Education for reaccreditation. Three hospitals and six organizations were reaccredited for four years. Two hospitals and one organization were given two-year provisional accreditation, which is standard accreditation for a new program. One hospital and one organization were placed on two-year probationary reaccreditation, and one hospital was given a two-year accreditation.

The Commission on Medical Education and the Subcommission on Accreditation updated the ISMA Guidebook and Application for Accreditation of continuing medical education in Indiana. Changes were necessary to fulfill the new "Standard for Commercial Support of Continuing Medical Education" set by the ACCME. The commission and subcommission will develop written materials and present meetings throughout Indiana to help providers of continuing medical education meet the new standards required by the ACCME.

The Commission on Medical Education responded to the ISMA Board of Trustees on two resolutions (92-6 and 92-29) dealing with physician distribution and Indiana residencies. Graduate medical education in Indiana and the report from the Council on Graduate Medical Education (COGME) were discussed. The Commission on Medical Education recommended that the board of trustees consider forming a state task force to address manpower issues.

The Undergraduate Medical Education Program at the Indiana University School of Medicine has new activities related to primary care. Twenty-three percent of the 1993 graduates entered a residency in family medicine (in 1992, it was 11%). Stephen Bogdewic, M.D., was appointed assistant dean for primary care education. Dr. Bogdewic will chair a task force that will study the four-year curricular program and recommend changes to support primary care. A part of the Introduction to Clinical Medicine course, dealing with the patient-doctor relationship and patient interviewing, is now in the first-year of medical study at the Indianapolis campus.

The members of the commission and subcommission have been busy with site surveys and implementing the new standards. The dedicated effort of these members is invaluable to medical education activities in Indiana. Dotty Martens and the ISMA staff have provided excellent support throughout the year.

COMMISSION ON PHYSICIAN ASSISTANCE
Kete Cockrell, M.D., chairman

1993 has been an industrious year for the Commission on Physician Assistance. We have worked closely with the Indiana Hospital Association (IHA) in an effort to increase our work with hospital administrators and hospital personnel. Both the ISMA and the IHA believe that increasing the knowledge base of those who work most closely with the impaired physician increases the likelihood that those in need will be intervened upon earlier. As a

result of our discussions, the IHA gave a $50,000 grant to the Physician Assistance Program. This joint effort will allow us to expand our opportunities in educating hospital administrators and personnel on early warning signs and the intervention and monitoring of the impaired physician.

We also have been busy developing marketing materials to keep the awareness of our program at an increased level. A poster was created outlining warning signs of an impaired physician with our name and number to call for help, as well as the name and number of any local impaired physician committee. These posters will be hung in physician lounges and surgery areas. Look for them in your hospital physician areas!

An extensive pamphlet also has been developed this year. This is designed to aid hospitals and other interested parties who want information on the impaired physician. The pamphlet covers most questions regarding the identification, intervention and monitoring of the impaired physician and offers sample hospital policies for dealing with the physician.

Our work with the Indiana University Physician Assistance Committee has continued. The program staff has given presentations to all major departments regarding the services offered by the committee and continues to do so. The committee at IU meets quarterly.

COPA also continues to investigate new cases and monitor existing ones. Presently, we are monitoring 65 cases in the state. We continue to see a higher percentage of physicians who are in family practice and emergency room medicine. Chemical dependency and psychiatric problems continue to be the primary problems.

COMMISSION ON SPORTS MEDICINE
George Underwood, M.D., chairman

The Commission on Sports Medicine has been very active in the past, and we have a lot of work in the future. Even though the chairmanship changes, the members of the commission have continued their dedicated work.

An Athletic Nutrition Brochure, which was developed by the commission throughout the past three years, will be distributed by the IHSAA and Indiana Department of Education to Indiana schools grades seven through 12.

The commission has always had an excellent working relationship with the IHSAA, with Ray Craft attending our meetings. We have been given permission by the Illinois State Medical Association to print a brochure titled "Helmet Fitting and Removal," which will be distributed to Indiana High Schools Athletic Departments by the IHSAA. The brochure is designed for schools that do not have athlete trainers.

Tom Reynolds, an attorney, has volunteered to assist us with some sports-related legal questions.

There was an informative discussion concerning waivers for an athlete playing with a disability (i.e., a football player with one eye or one kidney). Ray Craft, IHSAA, and Tom Reynolds shed a lot of light (and curve balls) in obtaining a waiver from parents and minor athletes.

Anyone who wants more information on sports waivers should contact the Commission on Sports Medicine.

GRIEVANCE COMMITTEE
Richard B. Schnute, M.D., chairman

The Grievance Committee, including Max Hoffman, M.D.; Freeman Martin, M.D.; John Pless, M.D.; Susan Pyle, M.D.; and John Seward, M.D., investigated multiple complaints during the 1992-93 period and worked diligently to fairly resolve these issues.

Complaints included differences of opinion concerning diagnosis and treatment, fees and charges and accusations of improper deportment. Most misunderstandings resulted from inadequate communication or explanations. The committee strongly urges better communications between physicians and patients.

As chairman, I thank the committee members for their participation in resolving these problems.

INDIANA MEDICINE
George T. Lukemeyer, M.D., editorial board chairman

The editorial board of INDIANA MEDICINE reviewed 24 manuscripts from Aug. 1, 1992, to July 31, 1993. The board has continued its policy of having all scientific manuscripts reviewed by one or more members of the editorial board to determine their acceptability for publication. A significant number of articles are also submitted to outside reviewers for their evaluation and recommendations.

I would like to thank the following editorial board members

for their assistance in reviewing manuscripts: James R. Buechler, M.D., Terre Haute; Thomas J. Conway, M.D., Terre Haute; James W. Edmondson, M.D., Indianapolis; Robert L. Forste Jr., M.D., Columbus; Panayotis G. Iatridis, M.D., Gary; George C. Manning, M.D., Fort Wayne; Bruce F. Waller, M.D., Indianapolis; and Robert C. Ziss, M.D., Evansville. I also appreciate the participation of the medical students who have served on the board, Paul Forman, Franklin Roesner and Holly Mattix.

Cooper Research conducted a readership survey of INDIANA MEDICINE by telephone from April 19 to May 17. The survey showed that INDIANA MEDICINE is perceived to be of much more value to doctors today than three years ago, when a similar readership survey was conducted by Cooper Research. The recent changes in INDIANA MEDICINE, including a redesign and an emphasis on socioeconomic, practice management, legal, ethical, financial and regulatory issues, were considered positive by a 10-1 margin. Primary reasons given for liking INDIANA MEDICINE included the stories of local interest, the People section and legislative articles. The report concluded that the value of INDIANA MEDICINE is in providing relevant information of a local or statewide nature and that ISMA publications can become even more relevant to physician members by including articles that reflect the changing marketplace.

ISMA TASK FORCE ON THE ISMA/PICI PARTNERSHIP
C. Dyke Egnatz, M.D., chairman

I am pleased to report that the ISMA Task Force on the ISMA/PICI Partnership has embarked on an aggressive program of activities to strengthen the ties between the two organizations for the benefit of all ISMA members.

A news release announcing the task force's formation and purpose from John MacDougall, M.D., representing PICI's leadership, and William Beeson, M.D., ISMA president, was distributed to medical publications and organizations.

The same information was sent to all members in the *ISMA Task Force Report*, an insert to *ISMA Reports*.

The PICI Marketing Department plans to complete and distribute a brochure highlighting the activities and advantages of the ISMA/PICI partnership.

PICI has announced the establishment of a Risk Management Hotline, a tollfree telephone service to provide quick answers to specific risk management questions of immediate importance. The hotline is staffed by PICI risk management specialists during normal working hours.

PICI also has announced to all Indiana specialty societies the availability of specialty-specific risk management seminars, in response to Dr. Beeson's request for this additional type of risk management service. The company is available to conduct a seminar in conjunction with a specialty society's annual meeting or as a separate activity.

PICI held an open house and reception for ISMA leaders at its office in conjunction with the August meeting of the ISMA Board of Trustees.

A new partnership theme was developed: PICI/ISMA – A Second Decade of Leadership.

PICI ... our company ... has completed its first decade of highly successful operations. It truly has demonstrated leadership by providing physician coverage and service concepts not previously available in our state.

Now, PICI has entered its second decade of leadership. We believe it is time for all ISMA members to take note of the company's services and efforts on our behalf. Thank you. ❑

resolutions

Status of 1992 resolutions

RESOLUTION 92-1A	**Prohibit Corporal Punishment in Indiana Schools**
Introduced by:	John Luce, M.D., LaPorte County
Referred to:	ISMA Commission on Legislation and Legislative Department
Status:	Senate Bill 636 was introduced into the 1993 General Assembly by Sen. John Sinks to implement this resolution but died in committee.

RESOLUTION 92-4	**Health Care in Nursing Facilities**
Introduced by:	ISMA Section on Medical Directors and Staff Physicians of Nursing Facilities
Referred to:	Board of Trustees (1st resolve) and Commission on Legislation and Legislative Department (2nd resolve)
Status:	1st resolve - ISMA has not met with the Indiana Health Care Association to help improve their per diem reimbursement. Physician reimbursement has been a major issue this session, and ISMA has not accumulated the political capital to go to bat for nursing homes. 2nd resolve - Two living will bills were introduced: one introduced by Rep. Bob Hayes and the other by Sen. Sue Landske. Neither passed.

RESOLUTION 92-5	**Legislation – Third-Party Payors**
Introduced by:	Fourth District Medical Society
Referred to:	Commission on Legislation and Legislative Department
Status:	Rep. Ed Goble introduced House Bill 1766, which was assigned to the Insurance Committee but did not receive a hearing.

RESOLUTION 92-6	**Physician Distribution**
Introduced by:	Richard Spalding, M.D., Sellersburg
Referred to:	Commission on Medical Education
Status:	Commission on Medical Education met and discussed this resolution on April 18 and is supportive of developing financial incentives for attracting graduating medical students to primary care and rural practice. James Carter, M.D., testified in support of pending legislation that included a loan forgiveness program for students going into primary care. The Commission supports the development of a "strategic plan" to address physician manpower issues in the state. The Commission believes the issue extends beyond educational matters. The Commission suggests consideration of the development of a task force that could consider all elements of this issue.

RESOLUTION 92-7	**Medicare Reimbursement**
Introduced by:	Third District Medical Society
Referred to:	ISMA Medicare Coalition and Indiana Delegation to the AMA
Status:	The Indiana AMA Delegation introduced Resolution 92-107 at the December 1992 AMA Interim Meeting. The House of Delegates reaffirmed current AMA policy in lieu of the resolution. The issue also was discussed at an ISMA Medicare Coalition meeting. Comments were directed to the HCFA Regional Office.

RESOLUTION 92-8 **ISMA's Annual Meeting Date**
Introduced by: Richard Huber, M.D., Bedford
Referred to: Board of Trustees
Status: Implemented by inclusion in the ISMA Policy Manual.

RESOLUTION 92-10 **A Leadership Development Source for ISMA**
Introduced by: Thomas Brubaker, M.D., and Bernard Emkes, M.D.
Referred to: ISMA General Counsel and Communications Department (1st resolve) and Board of Trustees (2nd resolve)
Status: When AMA-HMSS representation reaches at least 20, specific staff recommendation will be made to the Board of Trustees regarding appropriate meetings for this group. Letter to be sent to ISMA Delegates/Alternates before the AMA/HMSS meeting in June.

RESOLUTION 92-12 **Re-Establishment of "800" Medicare Number**
Introduced by: Lake County Medical Society
Referred to: ISMA Medicare Coalition
Status: The issue was placed on the agenda for two Medicare Coalition meetings. A letter was also written to HCFA. The response: "The Health Care Financing Administration has not funded a telephone line to re-establish the toll-free service for providers in FY 1993."

RESOLUTION 92-13 **Simplification of Billing Procedures**
Introduced by: Broad Ripple Family Physicians
Referred to: Refer to ISMA Legal Counsel
Status: Action plan presented at the May Board meeting with results of the insurance reform survey. A task force will be formed to work with the results and the insurance commissioner's office to develop or modify the insurance products and procedures.

RESOLUTION 92-14 **Medicare for Indiana**
Introduced by: Vigo County Medical Society
Referred to: ISMA Medicare Coalition
Status: An impact analysis request was sent to HCFA; their analysis is available at ISMA headquarters. This analysis was sent to specialty societies and ISMA leadership. It also was mentioned at an ISMA Medicare Coalition meeting. If ISMA can document overwhelming support by July 1, 1993, the resolution could be in effect Jan. 1, 1994. Staff provided an update at the May board meeting of the few responses received from the complete mailing.

RESOLUTION 92-15 **Mandatory Computerization of Patient Records**
Introduced by: George Rawls, M.D., Indianapolis
Referred to: Indiana Delegation to the AMA
Status: The Indiana AMA Delegation introduced Resolution 809 at the December 1992 AMA Interim Meeting. The House of Delegates adopted the following substitute resolution:

"Resolved, That the American Medical Association strongly urge third-party payers and others to preserve the option of non-computerized medical records, with no disincentives and no punitive measures for those physicians who continue to use non-computerized medical records."

resolutions

RESOLUTION 92-16 **Electronic Billing (EB)**
Introduced by: George Rawls, M.D., Indianapolis
Referred to: ISMA Medicare Coalition
Status: A letter was sent to HCFA outlining the concerns expressed in this resolution.

RESOLUTION 92-17 **Second Medical Opinions**
Introduced by: George Rawls, M.D., Indianapolis
Referred to: ISMA Policy Manual for Inclusion
Status: Implemented by inclusion in the ISMA Policy Manual.

RESOLUTION 92-18 **Immunizations in Private Practice**
Introduced by: 12th District Medical Society
Referred to: ISMA Legislative Department
Status: Rep. Bill Crawford has introduced legislation to allow the department of health to distribute vaccines to private physicians' offices for Medicaid patients. Although the bill did not pass, it is likely that action at the federal level will result in more widespread distribution of vaccines.

RESOLUTION 92-20 **Family Violence**
Introduced by: John Knote, M.D., Lafayette
Referred to: ISMA Communications Department
Status: Met with auxiliary in January. Spent 12-14 hours doing research on domestic violence materials. Established contacts with several providers of services to victims. Mailed information on domestic violence to all primary care ISMA members.

RESOLUTION 92-21 **Testing for Human Immunodeficiency Virus (HIV)**
Introduced by: Fort Wayne Medical Society
Referred to: ISMA Commission on Legislation and ISMA Legislative Department
Status: Rep. Dale Grubb introduced legislation to allow the department of health to designate one or more model HIV testing hospitals that would offer HIV tests upon hospital admission.

RESOLUTION 92-22 **CLIA Regulations**
Introduced by: Fort Wayne Medical Society
Referred to: ISMA Medicare Coalition (1st resolve) and Board of Trustees (2nd resolve)
Status: The Indiana AMA Delegation introduced Resolution 212 at the December 1992 AMA Interim Meeting. The House of Delegates reaffirmed current AMA policy in lieu of the resolution.

1st resolve – A new category of CLIA tests was created: "microscopy" category. When performed by a physician, the tests in this category are considered "moderately complex." The comment period on the HCFA regulation began Jan. 19, 1993.

2nd resolve - A questionnaire has been developed for mailing to local health officers.

RESOLUTION 92-24 **Endorsement of "Standards for Pediatric Immunization Practices" and its Adoption and Implementation by All Members**

Introduced by: John C. Bailey, M.D., Health Commissioner

Referred to: ISMA Communications Department

Status: Implemented through ISMA member mailing Nov. 25, which included the "Standards for Pediatric Immunization Practices." Budget impact not including postage was $2,655. Participated in Immunization Action Plan meeting Feb. 15 at Indiana State Department of Health. Published article on standards in January/February 1993 INDIANA MEDICINE.

RESOLUTION 92-25 **Due Process, Fair Hearing and Release of Selection Criteria by Managed Care Entities**

Introduced by: Vanderburgh County Medical Society

Referred to: ISMA Legal Counsel

Status: Legislation introduced but died in committee.

RESOLUTION 92-26 **Consumer Advocate within the State of Indiana Insurance Commission**

Introduced by: First District Medical Society

Referred to: ISMA Legislative Department

Status: Rep. Tom Alevizos introduced HB 1910 to provide for this position. Bill died in committee.

RESOLUTION 92-27 **Indiana State Health Policy Commission**

Introduced by: First District Medical Society

Referred to: ISMA Health System Reform Task Force

Status: No new physician appointments to the commission were made, so there was no opportunity for ISMA to gain an appointment to this commission.

RESOLUTION 92-28 **Distribution of Childhood Vaccine**

Introduced by: First District Medical Society

Referred to: ISMA Legislative Department

Status: 1st resolve - Rep. Crawford has introduced legislation that will allow the department of health to distribute free vaccine to private physicians' offices for immunizing Medicaid patients. Although the bill did not pass, it is likely that action at the federal level will result in more widespread distribution of vaccines.

2nd resolve - President Clinton has indicated interest in expanding immunization through distribution at the federal contract purchase price.

3rd resolve - The ISMA will be involved in a working group being formed by the state department of health.

4th resolve - Will be explored if all other options are fruitless.

RESOLUTION 92-29 **Indiana Residencies**

Introduced by: Vanderburgh County Medical Society

Referred to: ISMA Commission on Medical Education

Status: The Commission on Medical Education discussed this resolution with several concerns including:

1. Indiana taxpayers no longer support all Indiana residency training programs.
2. Some specialty training programs are only available in other states or have

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few positions in Indiana.
3. Residency program directors prefer to have a mix of geographic and training backgrounds in their residency groups.
4. Many of Indiana's current physicians who did their residencies in Indiana were not Indiana residents and have stayed in Indiana.
5. A policy like this might not be well received by the ACGME residency accrediting body.
6. If all criteria in the application of two residency candidates were similar except one was from out-of-state and one from in-state, it would appear appropriate to encourage acceptance of the Indiana resident.

No further activity was recommended by the Commission on Medical Education.

RESOLUTION 92-30 **Triplicate Prescription Program**

Introduced by: Vanderburgh County Medical Society

Referred to: ISMA Legislative Department

Status: Sen. Pat Miller introduced legislation to replace the triplicate prescription program with a "black box" prescription program. The ISMA defeated legislation that would have continued the triplicate prescription program.

RESOLUTION 92-31 **Peer Counseling During Malpractice Litigation**

Introduced by: Rajih Haddawi, M.D., Bloomington

Referred to: ISMA Legislative Department

Status: Action plan approved by Board of Trustees.

RESOLUTION 92-32 **Relinquish Medicare Filing Requirements for Non-Covered Services by Non-Participating Physicians**

Introduced by: C. Dyke Egnatz, M.D., Schererville

Referred to: ISMA Board of Trustees

Status: Discussed at ISMA Medicare Coalition meeting; information printed in January 1993 *Medicare Committee Report.*

RESOLUTION 92-33 **INCAP Support and Publicity**

Introduced by: C. Dyke Egnatz, M.D., Schererville

Referred to: ISMA Communications Department

Status: Distributed INCAP video and support materials to staffed county medical societies and notified members through *ISMA Reports* and INDIANA MEDICINE that videos are available for loan.

RESOLUTION 92-35 **Repeal of McCarran-Ferguson Act**

Introduced by: C. Dyke Egnatz, M.D., Schererville

Referred to: ISMA Legislative Department

Status: None

RESOLUTION 92-36 **Patient Compliance Rating**

Introduced by: C. Dyke Egnatz, M.D., Schererville

Referred to: ISMA Board of Trustees

Status: None

RESOLUTION 92-37 **Physician Assistants**

Introduced by: C. Dyke Egnatz, M.D., Schererville

Referred to: ISMA Board of Trustees

Status: Legislation addressing physician assistants was introduced by Sen. Pat Miller. The ISMA opposed prescribing privileges, and language providing for prescribing privileges was removed from the bill. The remainder of the bill will allow two PAs to be supervised by one physician.

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RESOLUTION 92-38 **Increased Hospital Privileges for Primary Care Physicians**

Introduced by: C. Dyke Egnatz, M.D., Schererville

Referred to: ISMA Legal Counsel

Status: ISMA will consult, advise and assist physicians who are denied hospital privileges based on criteria not reasonably related to individual ability and quality patient care.

RESOLUTION 92-39 **Insured to Help the Uninsured**

Introduced by: C. Dyke Egnatz, M.D., Schererville

Referred to: ISMA Board of Trustees

Status: Current AMA policy contains a provision for tax deductibility of health insurance benefits.

RESOLUTION 92-40 **Satellite Medical Services**

Introduced by: C. Dyke Egnatz, M.D., Schererville

Referred to: ISMA Legislative Department and Health System Reform Task Force

Status: ISMA secured an amendment to require the Medical Licensing Board to approve any nurse practitioner scope of practice expansion.

RESOLUTION 92-41 **Taxation of Health Care Benefits**

Introduced by: C. Dyke Egnatz, M.D., Schererville

Referred to: ISMA Board of Trustees

Status: None.

RESOLUTION 92-42 **Health Access Indiana**

Introduced by: Stephen Tharp, M.D., Frankfort

Referred to: ISMA Board of Trustees

Status:

a. Tuition abatement language included in SB 505
b. No increase in first draft of state budget.
c. Gov. Bayh announced that application will be submitted for HCFA waiver to implement case management.
d. Medicaid anti-hassle included in SB 505.
e. No meaningful insurance reform introduced in 1993.
f. No legislator would introduce helmet law.
g. Tobacco tax increase being pursued through Reps. Kruzan and Bayliff and Sens. Gery and Riegsecker.
h. No meaningful insurance reform introduced in 1993.

RESOLUTION 92-43 **New Physician Reimbursement**

Introduced by: Resident Medical Society

Referred to: ISMA Medicare Coalition

Status: The ISMA has corresponded with the Indiana Congressional delegation on this matter. Legislation correcting the inequity was passed but vetoed by President Bush for unrelated reasons. Legislation pursuing the correction will be pursued by AMA during 1993.

RESOLUTION 92-44 **Resident Membership**

Introduced by: Resident Medical Society

Referred to: ISMA Membership Department

Status: Pilot program will be offered in August for 1994 dues billing to new resident members to pay a $100 flat fee for three-year membership in the Resident Medical Society. Participation level and response to the program will be evaluated in 1994 .

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RESOLUTION 92-45 **Optometric Prescribing Liability**

Introduced by: Paul Honan, M.D., Lebanon
Referred to: ISMA Legislative Department
Status: Senate Bill 189, introduced by Sen. Dick Thompson, passed the Senate 50-0 and passed the House of Representatives. Died in the House Rules Committee.

RESOLUTION 92-46 **Delegation of Medical Authority by Physicians**

Introduced by: Ralph Stewart, M.D., Vincennes
Referred to: ISMA Board of Trustees
Status: None.

RESOLUTION 92-47 **Mandatory Referral Criteria**

Introduced by: Ralph Stewart, M.D., Vincennes
Referred to: ISMA Board of Trustees and ISMA Legislative Department
Status: None.

RESOLUTION 92-48 **Recommendation for the Use of Polycarbonate Clear Face Guards Worn by All Baseball Players in Organized Baseball, Ages 5-14**

Introduced by: Stephen Perkins, M.D., Indianapolis
Referred to: ISMA Commission on Sports Medicine
Status: None.

RESOLUTION 92-49 **Allow Competitive Physician Salaries Despite "Safe Harbor" Regulations**

Introduced by: Alvin Haley, M.D., Indianapolis
Referred to: Indiana Delegation to the AMA
Status: AMA Delegation introduced resolution at December 1992 meeting. It was not adopted by the House of Delegates. ❑



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Double cardiac valve replacement: A community hospital experience

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Abstract

The morbidity and mortality of double cardiac valve replacement were assessed in a community hospital setting. Four hundred twenty-two cardiac patients undergoing valve replacement from 1977 to 1991 were analyzed. Forty-two patients underwent double valve replacement. The clinical variables associated with increased operative mortality (early and late) were determined. The overall operative mortality rate for valve replacement was 7.87% (29 of 422 patients). The mortality rate was 9.09% (3/33 patients) for double valve replacement and 11.11% (1/9 patients) for double valve replacement in conjunction with coronary bypass. The clinical variables associated with increased mortality were: significant reduction in preoperative left ventricular ejection fraction (< 35%); advanced age (> 60); presence of ischemic mitral valve disease; and preoperative functional class (New York Heart Association Functional Class IV).

The results of this study suggest that strategies to diminish operative mortality should include assessment of risk preoperatively as well as anticipation of high mortality in selected subgroups.

The purpose of this report was to assess morbidity and mortality following double cardiac valvular operation in a community hospital setting. Preoperative ventricular function was evaluated in relation to long-term morbid events. Mortality was defined as death within 30 days if the patient was discharged or any time after if the patient was not discharged.[1]

The definitions of morbidity were as follows: structural valve deterioration, nonstructural valve dysfunction, thromboembolic events, anticoagulant-related hemorrhage and prosthetic valve endocarditis. Structural deterioration involved any intrinsic abnormality causing stenosis or regurgitation. This included valve wear, tear, stress, calcification or fracture.[2,3] Nonstructural dysfunction was any abnormality resulting in stenosis or regurgitation that was not intrinsic to the valve itself. Anticoagulant-related hemorrhage was described as any episode of bleeding that causes death, stroke, operation or hospitalization or requires transfusion.[1] Finally, prosthetic valve endocarditis included any infection involving a heart valve substitute.[1]

Valve-related morbidity and mortality included all operative deaths, all valve-related deaths including sudden and unexplained deaths and nonfatal permanent valve dysfunctions that require reoperation.[1]

This article will identify factors responsible for operative mortality after multi-valve surgery in a community hospital setting.

Methods

The patient group was selected from 422 cardiac valvular operations performed from 1977 to 1991. All valvular operations were performed by a single surgical group (three surgeons) at three community hospitals in Fort Wayne – Parkview Memorial Hospital, Lutheran Hospital and St. Joseph Medical Center. The valvular operations were divided according to position – mitral, aortic or both – and whether or not a coronary artery bypass (CAB) was performed. There were 33 double valvular operations and nine double valvular operations with a CAB. The most common valve placed in the double position was the

Carpentier-Edwards porcine valve. Mechanical valves were second with the St. Jude bi-leaflet valve.

The double valve group consisted of 13 men and 18 women. The double valve plus a CAB group consisted of four men and five women. The average age was 54.8 years, with ages ranging from 24 to 81 years. Valves placed in the mitral position and those with a CAB numbered 127 and 57, respectively. Valves placed in the aortic position and those with a CAB numbered 123 and 73, respectively.

Ventricular function was assessed by the preoperative ejection fraction, which was determined from two clinical echocardiograms. The preoperative ventricular function was then ranked as mild (EF 45-55%), moderate (EF 35-44%) or severe (EF <35%) impairment. The patients' preoperative clinical condition also was assessed and stratified according to clinical impairment. If a patient had a reduced ejection fraction but walked into the hospital without assistance, he would have mild clinical impairment (NYHA FC I-II). However, if the patient had an ejection fraction of 55% but was bedridden on inotropic support, he would be placed in the severe clinical impairment group (NYHA FC IV). The office and hospital records were carefully reviewed to determine the occurrence of postoperative morbid events and/or valve-related deaths.

Results

Early mortality for the entire series was 6.87% (29/422). The mortality of the double valves was 9.09% (3/33), and the mortality of double valves with a CAB was 11.11% (1/9). These numbers were similar to other mortality studies.[5-7] The lowest mortality group was the isolated mitral valve replacements (2/127, 1.57%). The highest mortality group was those associated with mitral valve replacements plus a CAB (12/57, 21.05%). Other studies that included mitral valve replacement with a CAB reported mortality rates ranging from 14% to 24%. The clinical variables identified for increased mortality were reduced ejection fraction, older than 60 years of age, NYHC Class IV symptoms and ischemic mitral valve disease.[8-12] The mortality for isolated aortic valvular operations was 5.69% (7/123), and the mortality rate for aortic valves plus a CAB was 5.48% (4/73). All data are illustrated in *Figure 1* and *Figure 2*.

For the isolated double valvular operations, five were placed in the severe class. Only one of these patients, whose operation was in 1983, is alive. All three of the operative mortalities for the isolated double valves were in this class. One patient died two days after surgery and the other five days after surgery. The other two patients in this class were free from morbid events.

Seven patients placed in the moderate impairment class received double valve replacement; four of these patients are deceased *(Figure 1)*. In three of the deceased patients (two died seven months after surgery and one nine months after surgery), the actual cause of death was not determined. However, a valvular origin was suggested.

Nineteen patients in the mild impairment class underwent double valve replacement. Of this group, three are deceased, with no operative mortality. Two deaths were from cardiac arrest; one was five years after surgery, and the other was one year after surgery. Autopsies were not performed on

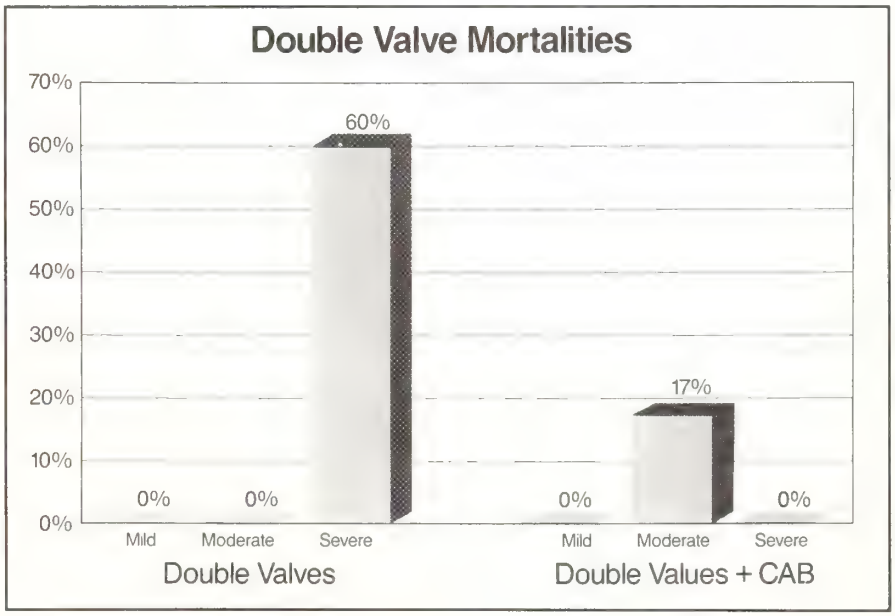


Figure 1

either patient. The other death occurred seven years after surgery from acute myocardial infarction and congestive heart failure. This group (mild impairment) was divided into operations occurring before 1986 and those occurring after. There were 12 patients in the pre-1986 group. This group included all four double valvular reoperations and all three deaths. All reoperations in this group involved the replacement of a failed porcine valve with mechanical valve.

Five-year freedom from morbid events in the mild impairment, pre-1986 group was 83.3% (10/12). Both morbid events were deaths of unknown etiology but reported as cardiac arrest. The 10-year avoidance of morbid events was 33.3% (3/9).

All seven patients in the post-1986 group are alive and well. Two patients had previous single valvular surgery before their double operation. One was in the mitral position (four years before surgery), and the other was in the aortic position (five years before surgery). There was one postoperative reoperation involving a patient with a malfunctioning aortic valve. This was the only morbid event in the post-1986 group to require hospitalization. This represented 23 patient-years of freedom from morbid events from a total 24 living patient-years.

Only one patient in the severe impairment class had a double valve operation plus a CAB. After the operation, he experienced renal and respiratory failure. Eight years before his double valve operation, he had a porcine valve placed in the aortic position plus a CAB. Despite all of these problems, he survived the operation and was sent home. He committed suicide four months after his operation.

Six patients were in the moderate impairment, double valve plus CAB class. Three are alive and well, one was an operative mortality, one is deceased, and one was lost in follow-up. Avoidance of morbid events for three years was 66.7% (2/3), with one patient experiencing severe gastrointestinal bleeding problems due to warfarin therapy. These three patients represent 14 living patient-years with avoidance of morbid events for 11 patient-years.

Only two of the remaining double valve patients with a CAB were placed in the good class. Both of these operations occurred recently (1989 and 1990), which limits the assessment of long-term outcome. The other patient was free from morbid events for her 1.5-year postoperative period.

Discussion

Ejection fraction has been described as a reasonable predictor of morbidity and mortality following open-heart operations.[4-13] One study has suggested that ejection fraction is a more accurate predictor of operative mortality than either decreased cardiac index or increased left ventricular end-diastolic pressure for valvular operations.[14] Hammerstein and coworkers concluded that the New York Heart Association functional classes for severity of coronary artery disease did not accurately predict an unfavorable outcome.[15] Based on these studies and the preceding data, ejection fraction is a good method of evaluation for early morbidity and mortality following a double valvular operation.

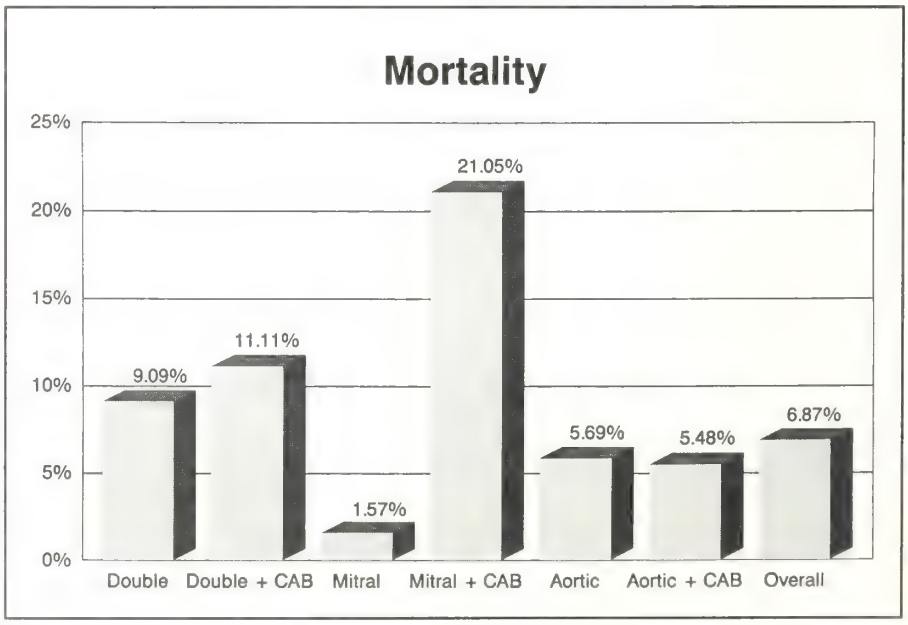


Figure 2

A definite pattern appears upon combining the double valves and the double valves plus a CAB categories and assessing the different classes. Operative mortality is almost entirely centered in the severe impairment class (4/5). An isolated operative mortality was in the moderate impairment class, and she was a type II diabetic, had a three-vessel bypass and required three exploratory operations for postoperative bleeding. Comparison of the three classes would be statistically inaccurate. However, combining the severe and moderate impairment classes and then comparing those with the mild impairment class in relation to morbid events can be done. This would place the severe and moderate impairment class count at 19 patients and the mild impairment class count at 21 patients. Of the patients who are deceased, most are in the severe and moderate impairment classes. Two of the deaths in the severe/moderate impairment class and one in the mild class were determined to be non-valve related, but this still leaves four in the severe/moderate impairment class and two in the mild class. All four of those deaths occurred within two years of their double valvular operation. One of the deaths in the mild class occurred within two years (one year four months), and the other did not occur until five years after surgery.

The morbid events have a much greater prevalence in the severe and moderate impairment class than those in the mild class. Dividing the severe/moderate class into a pre-1986 group and post-1986 group demonstrated that freedom from morbid events for five years (excluding operative mortalities and patients who died of other causes within the five-year period) was 50% (4/8). This is significantly lower than the mild impairment group's 83.3%. The 10-year freedom is too small for accurate comparison with the mild impairment group. Only three patients had their operations before 1981, and all have experienced morbid events. The five patients in the post-1986 group represent 11 living patient-years with nine patient-years of freedom from fatal morbid events. There was one valve-related mortality in this group.

In dealing with mortality, the type of valve used is not important.[16,17] Morbidity and valve type, however, are very important because of the different ways morbidity can be defined. This article considers death, reoperation and permanent valvular dysfunction the result of morbid events and, therefore, must be included.[1] Cobanoglu and coworkers do not consider a successful reoperation to be a morbid event.[18] Using this definition, the morbidity of the mild impairment class drops considerably. The five-year freedom from morbidity remains unchanged for the mild impairment class and the severe and moderate class, but the 10-year freedom for the good class jumps from 33.3% to 55.6% (5/9).

The 10-year freedom rate for the severe and moderate class does not change. Overall, the mild impairment class would lose five of its morbid events if post-double valve reoperations were eliminated, whereas the severe and moderate impairment class would lose only two. This would even further favor the mild class as having less of a problem with morbid events.

Summary

The current study confirms previous reports that have identified clinical predictors of increased operative mortality associated with double valve replacement. This research confirms that the experience in the community hospital setting is similar to the experience observed at large cardiovascular surgical centers. Strategies to reduce operative mortality should include careful preoperative assessment of risk and institution of operative techniques that might limit mortality such as improved myocardial protection in high-risk patients. ❑

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References

1. Edmunds HL, Clark RE, et al: Guidelines for reporting morbidity and mortality after cardiac valvular operations. *Ann Thorac Surg*, 46:257, 1988.

2. Weisel RD, Miller CD: Guidelines for reporting the performance of cardiac valve prosthesis. *Cardiac Surgery: State of the Art Reviews*, 1(2):215-546, February 1987.

3. Wernly JA, Crawford MH: Choosing a prosthetic heart valve. *Cardiology Clinics: Valvular Heart Disease*, 9(2):329-338, May 1991.

4. Milano A, Vouhe PR, Baillot-Vernant F, et al: Late results after left-sided cardiac valve replacement in children. *J Thorac Cardiovasc Surg*, 92:218-255, 1986.

5. Duncan JM, Cooley DA, et al: Durability and low thrombogenicity of the St Jude medical valve at five-year followup. *Ann Thorac Surg*, 42:500, 1986.

6. Christakis GT, Weisel RD, David TE, et al: Predictors of operative survival after valve replacement. *Circulation*, 78 (suppl 1):125, 1988.

7. Sethi GK, Miller CD, Souchek J, et al: Clinical, hemodynamic and angiographic predictors of operative mortality in patients undergoing single valve replacement. *J Thorac Cardiovasc Surg*, 93:885-887, 1987.

8. Czer LSC, Gray RJ, DeRobertis MA, et al: Mitral valve replacement: Impact of coronary artery disease and determinants of prognosis following revascularization. *Circulation*, 70 (suppl 1):1-198,1984.

9. DiSesa VJ, Cohn LH, Collins JJ, et al: Determinants of operative survival following combined mitral valve replacement and coronary revascularization. *Ann Thorac Surg*, 34:482, 1982.

10. Kennedy JW, Kaiser GC, Fisher LD, et al: Clinical and angiographic predictors of operative mortality: The collaborative study in coronary artery surgery. *Circulation*, 63:793, 1981.

11. Miller DC, Stinson EB, Rossites SJ, et al: Impact of simultaneous myocardial revascularization on operative risk, functional result and survival following mitral valve replacement. *Surgery*, 84:848, 1978.

12. Kirklin JK, Naftel DC, Blackstone EH, et al: Risk factors for mortality after primary combined valvular and coronary artery surgery. *Circulation*, 79 (suppl 6):1185, 1989.

13. Tyers GFO, Williams DR, Babb JD, et al: The changing status of ejection fraction as a predictor of early mortality following surgery for acquired heart disease. *Chest*, 71:371, 1977.

14. Cohn PF, Gorlin R, Cohn LH, et al: Left ventricular ejection fraction as a prognostic guide in surgical treatment of coronary and valvular heart disease. *Am J Cardiol*, 34:136,1974.

15. Hammerstein KE, Kennedy JW: Predictors of surgical mortality in patients undergoing direct myocardial revascularization. *Circulation*, 50 (suppl 2):112, 1974.

16. Sauvage LR: A comparison of the first 24 months of 65 St. Jude, 65 Bjork-Shiley and 49 Hancock aortic and mitral valve prostheses. In: Debakey, ME, ed. *Advances in Cardiac Valves: Clinical Perspectives*. New York, NY: Yorke Medical Books; 1983: 108.

17. Schonbek M, Egloff L, Kugelmeier J, et al: Porcine bioprostheses versus mechanical substitutes: A retrospective comparative analysis. In: Cohn LH, Galluce V, eds. *Proceedings of the Second International Symposium – Cardiac Bioprostheses*. New York, NY: Yorke Medical Books; 1982: 200.

18. Cobanoglu A, Jamieson WRE, Miller DC, et al: A tri-institutional comparison of tissue and mechanical valves using a patient-orientated definition of "treatment failure." *Ann Thorac Surg*, 43:245, 1987.

19. Rahimtoola S: Following the patient with prosthetic heart valves. In: Matloff JM, ed. *Cardiac Valve Replacement: Current Status*. Boston, MA: Academic Press; 1985: 3.

20. Burckhardt D, Striebel D, Vogt S, et al: Heart valve replacement with St. Jude Medical Valve, long-term experience. *Circulation*, 78 (suppl 1):118, 1988.

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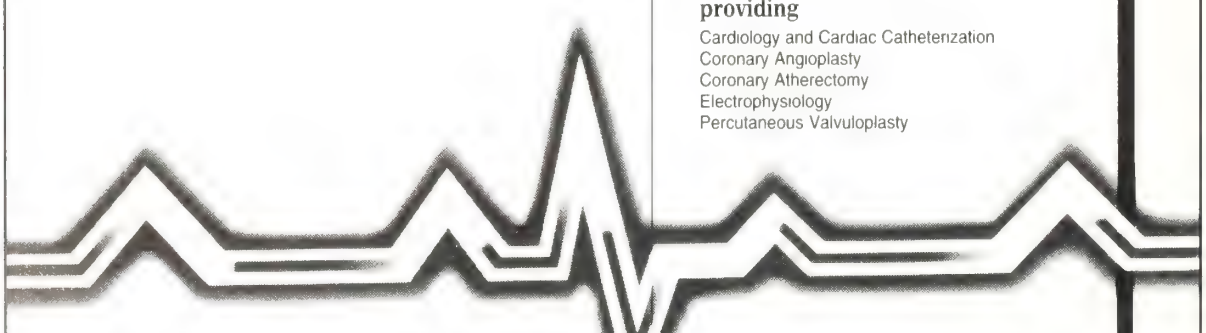
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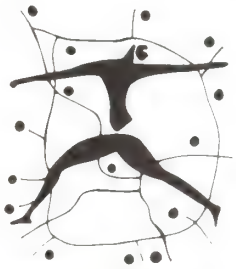
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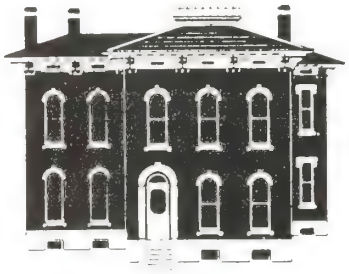


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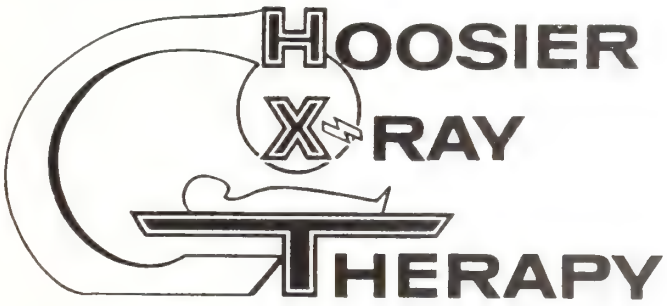
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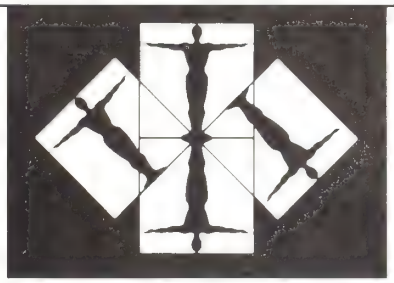
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alliance report

Sue Ellen Greenlee
ISMA Alliance president

The AMA Alliance annual House of Delegates was held in Chicago in June. The Indiana delegation consisted of Sue Ellen Greenlee, Valerie Gates, Terry Wallace, Donna Dersch, Trudy Urgena and Shirley Becker. Health Promotions Committee Chairmen Joan Wehlage and Diane Quinn and Legislative Affairs Chairman Jeannie Houck attended the presentations in their respective areas.

Indiana was recognized for achieving a federated membership of more than 75% and for establishing a new county alliance in Dubois County. Indiana's annual report was given by Trudy Urgena, immediate past president. Highlights of the convention included the adoption of a bylaw change that officially permits the usage of our new name, AMA Alliance, and the installation of Mary Hanson from Colorado Springs as the new national president.

ISMA Annual Convention: A continuing partnership

Indiana Alliance members will join ISMA members for many of this year's convention activities, continuing a strong partnership between the two groups. These activities will include a health care reform forum. Alliance county presidents, past and present, will be honored. Mark your calendars now for the October convention!

Please note the new Alliance logo in this article. The logo resembles the ISMA logo – a reflection of the true partnership that exists and grows stronger each day. ❑

INDIANA STATE MEDICAL ASSOCIATION ALLIANCE



Pictured at the 1993 AMA Alliance annual meeting in Chicago are: front row (left to right) Valerie Gates, Valparaiso; Sue Ellen Greenlee, ISMA Alliance president, Kendallville; Trudy Urgena, Marion; and back row (left to right) Rosanna Iler, ISMA Alliance coordinator, Indianapolis; Terry Wallace, Fort Wayne; Ann Wrenn, Bloomington; Donna Dersch, Muncie; and Shirley Becker, Evansville.

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The membership renewals or new memberships comprise most of the museum's funding. During fiscal year 1992-1993, more than 2,200 physicians acquired or renewed their memberships by marking the "Med-Mus" box.

As a member, a person receives four issues of *Snakeroot Extract*, the museum's newsletter; free admission to the museum; guided tours of the historic structure; and invitations to exhibit openings and special programs. A member also receives a special discount on the rental fee for the use of the museum for professional conferences, receptions or personal events.

Yet, these items represent only the measurable or tangible benefits of membership. The Indiana Medical History Museum also offers various intangible benefits as well.

Membership enables a person to help maintain and preserve the Old Pathology Building, which houses the Indiana Medical History Museum. As the nation's oldest surviving pathology laboratory, the building originally provided physicians in the late 1800s and early 1900s with state-of-the-art facilities in which to study mental and nervous disorders.

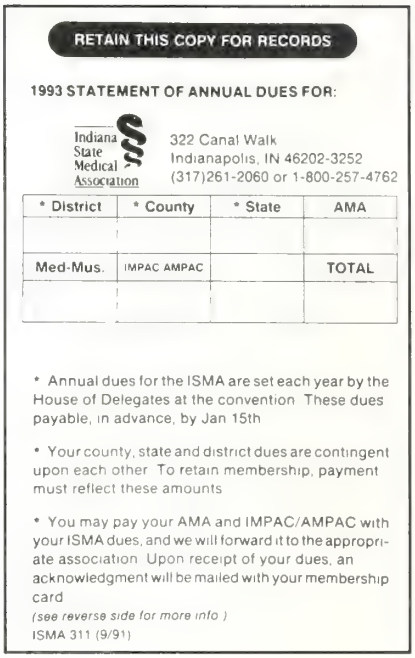
Martin R. Lipp, M.D., described the uniqueness of the Old Pathology Building in his book *Medical Landmarks USA: A Travel Guide* (1991), which describes more than 600 historical sites, medical landmarks and diverse museums. The author writes, "This marvelous museum is quite simply without peer in the entire country."

Besides helping to preserve this unique historic structure, membership also enables a person to help increase the opportunities that tourists have to visit the museum. Since museum memberships have increased steadily through recent years, the Indiana Medical History Museum now remains open from 10 a.m. to 4 p.m., Wednesdays through Saturdays, and at other times and days by appointment.

As a result, visitation has increased from more than 1,200 tourists in 1991 to more than 2,600 tourists in 1992, the year the museum expanded its hours. Besides physicians, these visitors include nurses, pharmacists, dentists, other health care professionals, medical students and school children.

In addition, membership also enables a person to help educate numerous school children and various community groups about the many differences in health care between the 19th and 20th centuries. As an educational resource, the museum offers diverse exhibits and programs that explore the practice of medicine during Civil War, the impact of the germ theory, the treatment of the mentally ill historically and other significant topics.

A physician who marks the "Med-Mus" box on the ISMA dues statement receives these benefits each year. With that action, the physician becomes a member not only of the Indiana Medical History Museum but of a distinct group dedicated to preserving the heritage of the healing arts in Indiana. ❑



RETAIN THIS COPY FOR RECORDS

1993 STATEMENT OF ANNUAL DUES FOR:

Indiana State Medical Association

322 Canal Walk
Indianapolis, IN 46202-3252
(317)261-2060 or 1-800-257-4762

* District	* County	* State	AMA
Med-Mus.	IMPAC AMPAC		TOTAL

• Annual dues for the ISMA are set each year by the House of Delegates at the convention. These dues payable, in advance, by Jan 15th

• Your county, state and district dues are contingent upon each other. To retain membership, payment must reflect these amounts

• You may pay your AMA and IMPAC/AMPAC with your ISMA dues, and we will forward it to the appropriate association. Upon receipt of your dues, an acknowledgment will be mailed with your membership card

(see reverse side for more info.)

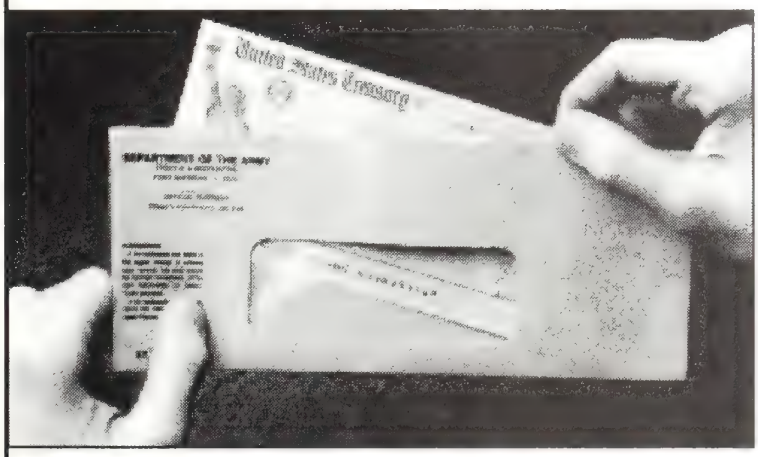
ISMA 311 (9/91)

The "Med-Mus" box on the ISMA dues statement enables a physician to become a member of the Indiana Medical History Museum. Memberships comprise the major source of the museum's funding.

Oren Cooley is the director of the Indiana Medical History Museum in Indianapolis. For information, call (317) 635-7329.

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cme calendar

Indiana University

The Indiana University School of Medicine will sponsor these courses:

Sept. 24 – Clinical Laboratory Improvement Amendments: How to Play the Game with the New Rules, University Place Conference Center, Indianapolis.

Sept. 28 – Advances in Pediatric Surgery: A Course for Pediatricians and Family Practitioners, University Place Conference Center, Indianapolis.

Sept. 30 – Update on Management of HIV Infection, University Place Conference Center, Indianapolis.

Oct. 1 – Recent Advances in Epilepsy, University Place Conference Center, Indianapolis.

Oct. 1-2 – Family Practice Update in Cardiology: Emphasis on Office Practice, Krannert Institute of Cardiology, Indianapolis.

Oct. 2 – Glaucoma Update, University Place Conference Center, Indianapolis.

Oct. 9-10 – Third Annual Stuart A. Kleit Symposium, Omni North, Indianapolis.

Oct. 23-24 – Advanced Trauma Life Support, Wishard Hospital, Indianapolis.

Oct. 29-31 – International Symposium on Advances in Laparoscopy and Colectomy, Westin Hotel, Indianapolis.

For more information, call (317) 274-8353. ❑

St. Mary's Medical Center

St. Mary's Medical Center in Evansville will sponsor these CME courses:

Sept. 16 – Annual Cancer Seminar: B Lymphocyte Disorders, Tri-State Hematology-Oncology Consultants, Evansville.

Oct. 23 – Annual Family Medicine Seminar, Primary Care Orthopaedics, Evansville.

For more information, call (812) 479-4468.

Center for Diagnostic Imaging

The Center for Diagnostic Imaging in Indianapolis will present its annual Imaging Conference Oct. 2 at the University Place Conference Center.

The conference is free of charge. For more information, call Tammy Hornung, (317) 846-0717 or 1-800-537-0005.

Methodist Hospital

Methodist Hospital of Indiana in Indianapolis will sponsor these CME courses:

Sept. 17 – Women in Medicine, Hyatt Regency, Indianapolis.

Sept. 18 – Health Care for the Homeless and Poor, Indiana Government Center, Indianapolis.

Oct. 1 – Managed Care Update, Petticrew Auditorium, Methodist Hospital, Indianapolis.

Oct. 8 – Neurology in Primary Care Medicine.

Oct. 15 – Medico/Legal Seminar, Petticrew Auditorium, Methodist Hospital, Indianapolis.

Oct. 15-16 – Ambuqual Users Conference, Hyatt Regency, Indianapolis.

Oct. 28-29 – Pelvic Floor Electrodiagnosis, San Antonio, Texas.

Oct. 30 – Cardiology for the Clinician.

For details, call (317) 929-3733 or 1-800-847-3370.

Reid Hospital

Reid Hospital and Health Care Services in Richmond will present High-Risk Obstetrics Mini-Seminar Sept. 30 from 6 p.m. to 9:30 p.m.

For more information, call Marie Hopper (317) 983-3112.

Clinical Training Associates

Clinical Training Associates of Indianapolis will present these CME courses:

Oct. 27 – Legal Issues in HIV Care: What is Confidentiality Anyway?, Indiana State Department of Health, Indianapolis.

Dec. 1 – Medical Management of the End Stage Patient in Extended Care, Parkview Manor, Indianapolis.

For more information, call Clinical Training Associates, (317) 631-5535. ❑

ARNETT CLINIC

About the Multispecialty Medical Group

Arnett Clinic has served Tippecanoe County and surrounding counties in Mid-North Central Indiana since 1922. Arnett physicians introduced the area's first dialysis service, performed the area's first open heart surgery, and developed the community's first heart catheterization laboratory. In seven outpatient facilities, over 100 specialists and subspecialists provide medical and surgical services in virtually every specialty field. The majority of Arnett's referral patients reside within a fourteen-county area surrounding Lafayette, Indiana, with a drawing area of over 320,000 people.

Ambulatory walk-in clinics in Lafayette and West Lafayette supplement primary clinic services. Arnett Urgent Care Centers are open from 8 a.m. until 8 p.m. every day, and staff members provide diagnosis and treatment for any medical problem which does not require ambulance transport.

Arnett physicians provide hospital support services at two nearby community hospitals, Home Hospital with 365 beds, and St. Elizabeth Hospital with 375 beds. Arnett has diversified into other healthcare fields, including Arnett Health Systems (an HMO) and the corporate affiliates of Arnett Medical Supply and Arnett Pharmacy.

Opportunities

The Arnett Clinic is currently seeking BE/BC candidates:
Cardiology
Dermatology
Family Medicine
General Internal Medicine
OB/GYN
Oncology
Orthopaedic Hand Surgeon
Pediatrics

Practice Setting

At this time, over 100 physicians work for Arnett Clinic. One of the most practical reasons for affiliation with Arnett is the availability of ancillary staff to support clinic operations. Administrative, Laboratory, and Radiology services are available on-site, making our practice environment an integrated, comprehensive, and convenient healthcare resource center. The patient base in Lafayette stems from a balanced mix of industrial and university communities. We are an equal opportunity employer.

Benefits

Our Medical Staff members enjoy competitive salaries and a generous benefit package. During the first two years of employment, Arnett offers a guaranteed minimum salary with a production bonus. After two years of successful practice experience, shareholder status with a productivity incentive formula is available. An excellent profit-sharing and investment plan is also available.

Other benefits include health coverage via Arnett HMO or other group insurance, disability, life insurance, and continuing education funds.

Community

Lafayette, Indiana is a thriving, low-crime community located in a county of approximately 132,000 people. Purdue University, known for academic leadership in the areas of engineering, agriculture, humanities, and sciences, and for Big Ten Sports, is nearby. Money Magazine recently identified Lafayette as one of the top 14 cities in which to live in the U.S.A.

For more information

Please contact: Physician Recruitment Department
Arnett Clinic, 2600 Greenbush Street
Lafayette, IN 47904 (317) 448-8000
Toll Free Nationwide, 1-800-899-8448

Lafayette, Indiana

obituaries

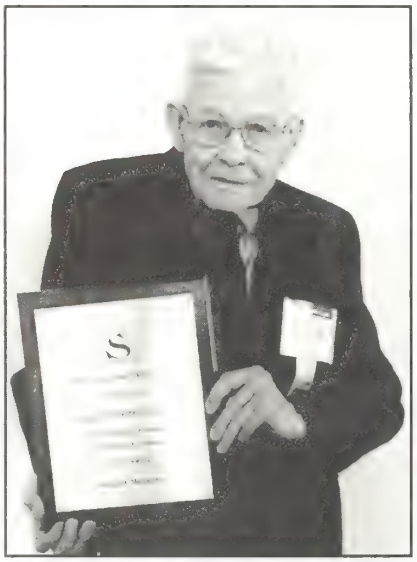
In memoriam: Frank B. Ramsey, M.D.

Frank B. Ramsey, M.D., 91, retired Indianapolis surgeon and editor of INDIANA MEDICINE for 41 years, died July 31, 1993.

Dr. Ramsey was only the third editor in the history of INDIANA MEDICINE, which was begun in 1908 as *The Journal of the Indiana State Medical Association.* He was named editor in 1949, after serving one year as associate editor. The magazine underwent several changes during his term, including the change in title and a conversion to desktop publishing. During Dr. Ramsey's editorship, INDIANA MEDICINE received several honors. Sandoz Pharmaceuticals presented first place awards in its medical journalism competition to INDIANA MEDICINE in 1976, 1979 and 1990 in recognition of excellence in design and editorial content. He retired and was named editor emeritus in 1990.

Dr. Ramsey helped form the State Medical Journal Advertising Bureau (SMJAB) in 1952 to sell national advertising for state medical journals. He served SMJAB as president, chairman and secretary/treasurer.

He came to the helm of INDIANA MEDICINE with a distinguished record of service in medicine. After graduating from the Indiana University School of Medicine in 1927, he served an internship at Indianapolis City Hospital (now Wishard Memorial Hospital) from 1927 to 1928. He



Dr. Ramsey displays the 1990 Sandoz Pharmaceuticals Medical Journalism Award given to INDIANA MEDICINE.

then served a residency in surgery at Robert Long Hospital in Indianapolis from 1928 to 1931, followed by a fellowship in surgery at the Lahey Clinic in Boston, Mass., from 1931 to 1933.

From 1933 to 1975, he had a private practice in surgery in Indianapolis. He served on the surgical staffs at the Indiana University Medical Center and Wishard Memorial, Methodist, St. Vincent and Winona hospitals and Sunnyside Sanatorium.

During World War II, Dr. Ramsey served with the 38th Infantry Division in the Pacific. He received the Bronze Star in 1945 and the Legion of Merit award in 1946 and left active duty as a full colonel.

He found time to serve as president of the board of managers of the Marion County Healthcare Center and as a member of the Indiana State Civil Defense Advisory Council.

When he retired from the practice of medicine, he was associate professor of surgery emeritus at the IU School of Medicine. The school named him Alumnus of the Year in 1979.

Dr. Ramsey was a member of Nu Sigma Nu medical fraternity and Alpha Omega Alpha honorary medical society and a fellow of the American College of Surgeons and the American Medical Writers Association.

Survivors include a sister, Lorena Ramsey Phelan, St. Petersburg, Fla.; nephews James A. Ramsey of Indianapolis, William D. Ramsey Jr. of Houston and Frank Phelan of Federal Way, Wash.; and a niece, Jane G. Scott, Santa Cruz, Calif.

Dr. Ramsey's family has established a special scholarship fund to benefit deserving medical students. Tax-deductible contributions may be sent to the Frank B. Ramsey Memorial Scholarship Fund, c/o the Indiana University Foundation, P.O. Box 500, Bloomington, IN 47402. ❑

Warmth, humor, generosity characterize Dr. Ramsey's life

Dr. Frank Ramsey was dedicated to making INDIANA MEDICINE the best state medical association publication in the country. As a result, it received many awards through the 41 years of his editorship.

My wife, Betty, and I enjoyed the warmth and friendship of Dr. and Mrs. Ramsey from the first time we met. What a sense of humor they both had. Their rich, warm, realistic human qualities made them people you wanted to know better and see more often.

After Mrs. Ramsey's death, Dr. Ramsey and I met for lunch occasionally and talked about everything and anything. From these talks, I learned of his special interests and his real character. Certainly one highlight of his life was becoming a surgeon. His respect and appreciation for the Lahey Clinic in Boston, where he served a fellowship in surgery, were apparent. He admired Dr. Lahey as a special person and teacher and modeled his career on his training with him. If the student was a reflection of the teacher, Dr. Lahey must have been another person of character and quality.

Dr. Ramsey was a scientific and enthusiastic gardener. The ISMA staff benefited from his fondness for toiling in the soil. He brought them onions, tomatoes, celery, lettuce and other fresh vegetables and exhibited an enormous pleasure in doing it.

He looked upon himself as part of the ISMA staff and they accepted him as such. He attended the staff's social functions and enjoyed himself to the utmost.

From the wooded area on his property, he cut much of his own wood for his fireplace, a favorite place for him and his many Dobermans to take an easy hour of comfort and reflection. He and Mrs. Ramsey raised 13 or 14 Dobermans.

Serving as a chief medical officer with the 38th Infantry Division in the Pacific during World War II was one of Dr. Ramsey's fondest accomplishments and memories. We discovered we had much in common. Because I had served in an infantry unit in France and survived severe wounds, we exchanged many stories of combat and medical care of the troops.

Dr. Ramsey was a good man. His life, his career and his personal relationships reflected everything that is decent, respectable and admirable in human character. He also had a warm personality, a wonderful sense of humor, a generous nature and a fine intelligence.

I will always remember him as a special person and consider it a distinct privilege to have known him. – *Ken Bush, Greenwood, retired assistant executive director, Indiana State Medical Association.* ❑

'The legacy he leaves will survive forever'

Frank B. Ramsey, M.D., who served as editor of INDIANA MEDICINE for 41 years, died July 31, 1993.

A retired surgeon who practiced in Indianapolis for 42 years, Dr. Ramsey was a scholar, teacher, surgeon, editor and a true friend to most physicians throughout the state of Indiana. I cannot recall a single physician who has ever made a bad comment about Dr. Frank Ramsey.

He was innovative, intelligent, amiable, courteous and of high moral character. He helped to achieve the high standards that the medical profession attempts to achieve and maintain. He has brought honor to himself and has distinguished medicine in the city of Indianapolis and the state of Indiana. I am certain that, as editor of INDIANA MEDICINE, he has made some major contributions to medicine on the national scene. Because of Dr. Ramsey – and others like him – the past three decades have witnessed a tremendous change in medicine as it is practiced today. We have noticed a marked decrease in many of the diseases that once plagued mankind. People are living longer and enjoying a better quality of life. There has been a trend toward prevention of disease. Medicine has seen endless technological advances.

Dr. Ramsey's foresight, influence, integrity and vision have paved the way for those of us who would like to emulate his many attributes and to continue to improve health care. Although Dr. Ramsey is no longer physically with us, the legacy he leaves with physicians in Indiana is indelible and will survive forever. ❑ – *William K. Nasser, M.D., Nasser, Smith & Pinkerton Cardiology, Indianapolis.*

obituaries

Paul Alvarez, M.D.
Dr. Alvarez, 62, a Valparaiso orthopaedic surgeon, died May 31, 1993, at his home.

He was a 1959 graduate of the Indiana University School of Medicine.

Dr. Alvarez was affiliated with the Valparaiso Orthopaedic Clinic for 20 years and was on the staff at Porter Memorial Hospital. He was a member of the American Board of Orthopaedic Surgery and the American Academy of Orthopaedic Surgery.

August J. Dian, M.D.
Dr. Dian, 86, a retired psychiatrist, died April 28, 1993, at his home in Tampa, Fla.

He was a 1931 graduate of the Indiana University School of Medicine.

Dr. Dian had a private psychiatry practice in Gary until 1976, when he moved to Bluffton and practiced at the Caylor-Nickel Medical Center until his retirement in 1982.

Francis A. Ferry, M.D.
Dr. Ferry, 69, a retired Indianapolis family physician, died June 12, 1993.

He was a 1951 graduate of the St. Louis University School of Medicine and an Army veteran.

Dr. Ferry was a physician on the Indianapolis southside 40 years, until his retirement in 1992. He had served as the medical director of Beech Grove Health Care Center and as the chief of staff at St. Francis Hospital. He was a member of the American Academy of Family Practice. In 1990, he was named Indiana Physician of the Year by Evergreen Healthcare Ltd.

Paul G. Lindenborg, M.D.
Dr. Lindenborg, 78, a retired Indianapolis family physician, died May 24, 1993.

He was a 1947 graduate of the Indiana University School of Medicine and was a Navy veteran of World War II.

Dr. Lindenborg opened his practice in Indianapolis in 1950 and was on the staff of Community Hospital East for 25 years. He also had been on the staffs at Methodist, St. Francis and St. Vincent hospitals before retiring in 1987.

Wayne G. Pippenger, M.D.
Dr. Pippenger, 86, former medical director at Ball State University, died May 29, 1993, at his home in Frankfort.

He was a 1930 graduate of the Indiana University School of Medicine.

Dr. Pippenger practiced medicine in Camden, Lafayette and Brook before becoming medical director at Ball State in 1955. After he retired from Ball State in 1972, he moved to Frankfort, where he was on the staff at Wesley Manor Retirement Home. He was past president of the Jasper-Newton County Medical Society and the Carroll County Medical Society and a co-founder of the Mid-America College Health Association. Dr. Pippenger was a member of the State Commission for Rural Medical Care, a charter member and fellow of the American College Health Association and a charter fellow of the American Academy of Family Physicians.

Virginia M. Wagner, M.D.
Dr. Wagner, 53, an Indianapolis pediatrician, died July 13, 1993.

She was a 1965 graduate of the Indiana University School of Medicine.

Dr. Wagner specialized in pediatric oncology during her nearly 30 years of practice. She was a clinical professor of pediatrics at the I.U. School of Medicine and on the staffs at Methodist, St. Vincent, Indiana University, Wishard Memorial and Women's hospitals and Lifelines of Indianapolis. She founded Camp Little Red Door, a camp for children with cancer, in 1980. Later she founded The Family Together Weekend, a program for family members of children with cancer. At Camp Riley for handicapped children at Bradford Woods, she was a counselor, physician, medical director and adviser. Dr. Wagner had served as president of the Little Red Door Cancer Agency and of the Indiana Medical Licensing Board. She was a member of the ISMA Commission on Legislation and often testified for the ISMA during hearings on proposed state legislation. ❑



Dr. Morrison

Dr. Andrew L. Morrison of Indianapolis was elected president of the board of directors of the Indiana Psychiatric Consortium. He has been in private practice since 1976 and is currently a spokesperson for the Mental Health Association's national public education campaign on clinical depression.

Dr. C. Conrad Johnston, professor of medicine and chief of endocrinology and metabolism at the Indiana University School of Medicine, received the 1993 Sandoz Prize from the International Association of Gerontology. He was recognized for his contributions to gerontological research, particularly in the areas of osteoporosis. The award was presented during the International Congress of Gerontology in Budapest, Hungary.

Dr. Robert D. Arnold, an Indianapolis obstetrician/gynecologist, received the Distinguished Service Award for 1993 from Planned Parenthood of Central Indiana for having made a significant contribution to the organization's mission; he has served Planned Parenthood since 1948 and is now one of two lifetime members of the board.

Dr. James B. Steichen, an Indianapolis hand surgeon, was elected president of the International Society of Reconstructive Microsurgery at its symposium in Vienna, Austria.

Activities of physicians from Northside Cardiology of Indianapolis include the following: **Dr. Thomas J. Linnemeier** spoke on "Intracoronary Ultrasound for Optimizing PTCA" at the 15th Congresso Brasileiro de Hemodinamica e Angiocardiografia in Recife, Brazil; he also presented an abstract titled "Does Intracoronary Ultrasound Assist Decision Making During Coronary Angioplasty?" at the Arizona Heart Institute International Congress VI in Phoenix. **Dr. Eric N. Prystowsky** was a guest lecturer at the International Workshop on Prevention of Tachyarrhythmias by Cardiac Pacing in Paris, France; he spoke on "Inhibition in the Human Heart" and participated in a round table discussion about the future for pacing techniques to prevent tachyarrhythmias. **Dr. Janet S. Rippy** was promoted to clinical associate professor at the Indiana University School of Medicine. **Dr. Joe Noble** will present an update in cardiovascular pharmacology at the Second International Cardiovascular Symposium in Athens, Greece. **Dr. Donald A. Rothbaum** co-authored an article titled "Chronic Total Obstruction and Short-Term Outcome: The Excimer Laser Coronary Angioplasty Registry Experience" that appeared in the January 1993 issue of *Mayo Clinic Proceedings*.

Dr. Richard D. Zeph, a Carmel facial plastic surgeon,

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

May 1993
Bobb, Kenneth E., Seymour
Collicott, Roger C., Plainfield
Domingo, Ricardo C., Greensburg
Donesa, Antonio B., Fort Wayne
Francoeur, Cleve J., Columbus
Gourieux, Edward De Verre, Evansville
Hecht, Joseph D., Munster
Howard, Michael D., LaPorte
Korba, Alvin, Evansville
Lentz, William C., Fort Wayne
Manders, Karl L., Indianapolis
Marske, Robert L., Michigan City
Mellinger, Michael O., LaGrange
Musselman, Robert H., Fort Wayne
Rex, Douglas K., Indianapolis
Wagoner, Don J., Burlington
White, Edward A., Evansville
Zunich, Janice, Gary

June 1993
Abshire, Vance M., Zionsville
Alexander, Panos C., Kokomo
Behrend, Frank L., Valparaiso
Callon, Robert A., Indianapolis
Collings, Chrissa L., Plainfield
Conard, Douglas S., Frankfort
Estacio, Romeo Y., Munster
Flint, Douglas R., Indianapolis
Galante, Albert, Munster
Graham, Nelson V., Evansville
King, Mark A., Fort Wayne
Kohr, Roland M., Terre Haute
Mantheiy, Joseph R., Liberty Center
Minick, Linus J., Churubusco
Pierce, William J., Merrillville
Strate, Bonnie Rhoads, Indianapolis
Wendell, Benjamin A., Linton

Omitted from Feb. 1993
Tirman, Wallace S., Scottsdale, AZ

people

spoke on facial soft tissue trauma at the soft tissue surgery course at the Indiana University Medical Center. He participated in a panel discussion on revision rhinoplasty in the aging patient and spoke on vermilion advancement/augmentation cheiloplasty at the Aesthetic Surgery of the Aging Face Meeting sponsored by the American Academy of Facial Plastic Surgery.

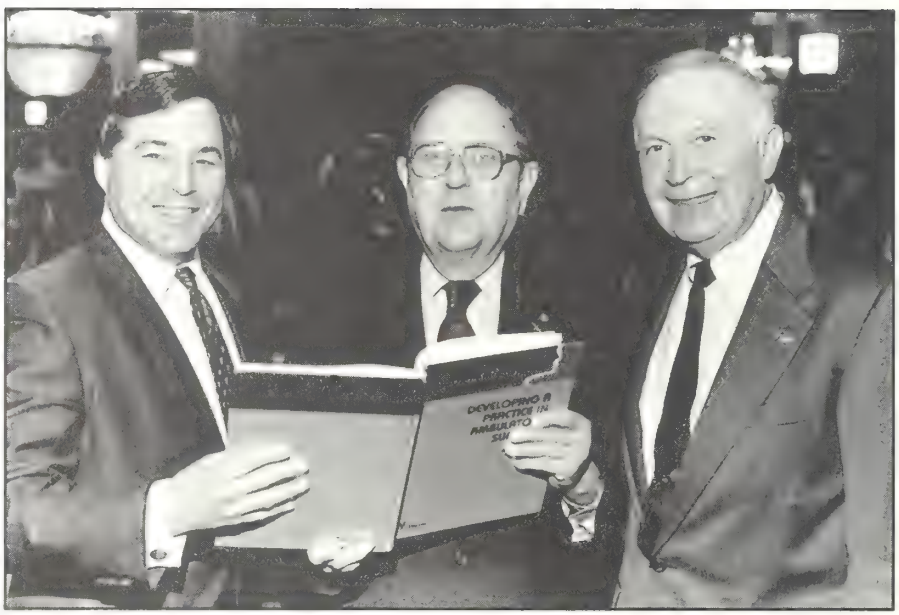
Dr. David L. Wallace, an Indianapolis internist, was re-elected to a special extended one-year term on the board of the Visiting Nurse Service in Indianapolis.

Dr. Vidyasagar S. Tumuluri, an Indianapolis hand surgeon, recently visited Riga, Latvia; Moscow, Russia; Kiev, Ukraine; and Prague, the Czech Republic, as a delegate of the International Federation of Societies for Surgery of the Hand. The tour was arranged to foster international friendship and advance worldwide communication among hand surgeons.

Activities of physicians from Nasser, Smith & Pinkerton Cardiology in Indianapolis include the following: **Dr. Charles M. Orr** spoke on "Thrombolytic Therapy: Old Questions and New Lessons from the GUSTO Trial" to a group of physicians from Terre Haute and the surrounding area. **Dr. Cass Pinkerton** was the instructor at a training class for the Cook Gianturoco-Roubin Flex Stent at the University of Alabama in Birmingham.

Dr. John R. Hayes, a partner in the Indiana Psychiatric Consortium and director of academic affairs at St. Vincent Hospital in Indianapolis, is serving a five-year term as a director of the American Board of Family Practice.

Dr. William H. Beeson, an Indianapolis facial plastic surgeon, was an instructor during the



William H. Beeson, M.D., left, an Indianapolis facial plastic surgeon, presents Jim Davis, M.D., center, past AMA president, with the first copy of his new book, *Developing a Practice in Ambulatory Surgery.* They are joined by Raymond Scalettar, M.D., AMA board chair, at the AMA meeting in Chicago. Dr. Beeson's book, co-authored with Howard Tobin, M.D., of Abilene, Texas, was recently released from Thieme Medical Publishers and is dedicated to Dr. Davis.

American Academy of Facial Plastic and Reconstructive Surgery Sixth International Symposium in San Francisco; he presented programs on "Lasers in Facial Plastic Surgery," "Management Techniques for Control of Facial Scarring: Dermabrasion and Chemexfoliation" and "Facelift: Anatomy and Approaches."

Two physicians recently received three-year appointments as cancer liaison physicians for hospital cancer programs. They are **Dr. Redmond P. Hogan III**, an Indianapolis hematologist, St. Francis Hospital in Indianapolis, and **Dr. John E. Marvel**, an Anderson radiation oncologist, St. John's Medical Center in Anderson.

Dr. Jerry L. Kight, director of the division of nuclear medicine at Methodist Hospital in Indianapolis, has been named a diplomate of the American Board of Medical Management.

Dr. Maurice John, a Jeffersonville ophthalmologist, was elected to a one-year term on the board of directors of the American Board of Eye Surgery.

Dr. Dean L. Strycker, a South Bend anesthesiologist, was elected chairman of the board of trustees of Memorial Hospital in South Bend.

Dr. Robert M. Seese has retired after 40 years as a family physician in Delphi.

people

Dr. David B. Tribble, a South Bend family physician, was elected to the board of directors of the Visiting Nurse Association of Michiana.

Dr. John C. Parker has retired after 35 years as a family physician in Goodland.

Dr. Cary L. Hanni, an Evansville vascular surgeon, was elected to the board of trustees of the University of Indianapolis.

Dr. Frank P. Lloyd, former president and chief executive officer of Methodist Hospital in Indianapolis, received an honorary doctor of science degree from Rose-Hulman Institute of Technology.

Dr. Don W. Boyer has retired after 31 years as a surgeon in Lebanon.

Dr. Douglas E. Carr, a Lawrenceburg surgeon, has been certified by the American Board of Surgery.

Dr. Larry D. Rink, a Bloomington internist, served as faculty for the Third Annual Southern Conference's Sports Medicine Symposium, sponsored by the Southern Medical Association in conjunction with the Southern Orthopaedic Association. He spoke on "Sudden Death in Athletes: Can We Prevent It?" and "Echocardiographic Evaluation of Athletes."

Three Kokomo physicians formed the winning team in a spelling bee sponsored by the Literacy Coalition of Kokomo-Howard County. The physicians, **Dr. Phil O. Burgan**, an obstetrician/gynecologist; **Dr. John P. Quakenbush**, a family physician; and **Dr. William J. Granger**, an anesthesiologist, advanced to the state spelling bee in Indianapolis.

Dr. George W. Sorrells, a Bedford pediatrician, received the Irving Rosenbaum Award for Community Service from the Indiana Chapter of the American Academy of Pediatrics.

Dr. Raymond E. Duncan, a Bedford family physician, was elected president of the Lawrence County Board of Health.

Dr. Norman Forrest, an obstetrician/gynecologist, was elected president of the medical staff at Memorial Hospital in South Bend. Other officers are **Dr. Rick Seall**, emergency medicine, vice president, and **Dr. Cheryl Wibbens**, emergency medicine, secretary-treasurer.

Dr. Bradley C. Black, a Jeffersonville ophthalmologist, was named the Southern Indiana Chamber of Commerce's 1993 Professional Person of the Year.

Dr. Ron Stegemoller, a Danville family physician, spent two weeks caring for the sick in Lahatte, Haiti, in a clinic organized by Missions of Love, a medical missionary group that serves the village.

Dr. Jack Lenox, a Lebanon family physician, was honored by the Indiana United Methodist Children's Home for his more than 20 years of service as the home's physician.

Dr. Peter P. Szumilas of Anderson has retired from obstetrics but will continue his gynecology practice; his final delivery, twin baby girls, was April 30.

Dr. Basil M. Salaymeh, a Greencastle vascular surgeon, was certified by the American Board of Surgery.

Dr. Sterling P. Tignor, a Kokomo surgeon, was named the Service Excellence Physician of the Year by Howard Community Hospital.

Dr. Jeffrey C. Darnell, an internist at Wishard Memorial Hospital in Indianapolis, was named the first recipient of an award from the Central Indiana Council on Aging that honors "gatekeepers" in the medical community. The award is being named in honor of Dr. Darnell, who donates his time to care for the elderly, and will go to someone who helps senior citizens in immediate need of assistance.

Dr. Horace O. Hickman, a Beech Grove cardiologist, was honored as an outstanding alumnus by Southport High School in Indianapolis.

Dr. Steven B. Ashton, a Warsaw otorhinolaryngologist and facial plastic surgeon, was named a fellow by the American Osteopathic Colleges of Ophthalmology and Otolaryngology, Head and Neck Surgery.

Dr. Saiful Kabir, an Anderson internist, was elected a fellow of the American College of Chest Physicians.

Dr. Stanley R. Adkins, a Columbus internist, was appointed vice president of the national American Heart Association and chairman of the association's north central heart committee.

Dr. Dale South, a family physician, and **Dr. Marvin E. Mishkin**, an internist, were recognized for their 25 years as physicians by Elkhart General Hospital.

Dr. Samuel M. Wentworth, a Danville pediatrician, led 32 insulin-dependent teenagers on an 800-mile bike trip through Michigan and Wisconsin. The purpose of the trip was to give the teens a chance to observe the effects of exercise on their diabetes.

Dr. Glenn W. Irwin Jr. of Indianapolis was elected president of the board of the Eiteljorg Museum of American Indian and Western Art.

people

New ISMA members

Cathy L. Bagley, M.D., Munster, obstetrics and gynecology.

David Baugh, M.D., Danville, pediatrics.

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CONTRAINDICATIONS

Hypersensitivity to any component of this medication

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS)

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY, Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS, Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin, the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin.* See WARNINGS, Skeletal Muscle.

Antipyrine. Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol. Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect (See DOSAGE AND ADMINISTRATION, Concomitant Therapy.)

Warfarin. In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine. The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin. In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil. In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs. During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*, a forward mutation assay in L5178Y TK +/− mouse lymphoma cells, a chromosomal aberration test in hamster cells, and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter^2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS, **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated, adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below, also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug.

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma, anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS, **Skeletal Muscle** and PRECAUTIONS, **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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INDIANA MEDICINE

The Journal of the Indiana State Medical Association

November/December 1993 Vol. 86, No. 6



HEALTH SYSTEM REFORM:
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INDIANA MEDICINE

The Journal of the Indiana State Medical Association

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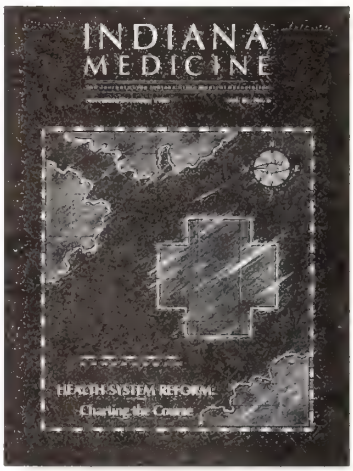
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Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

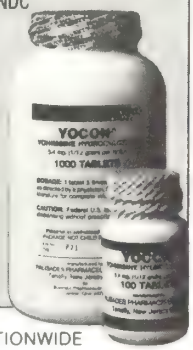
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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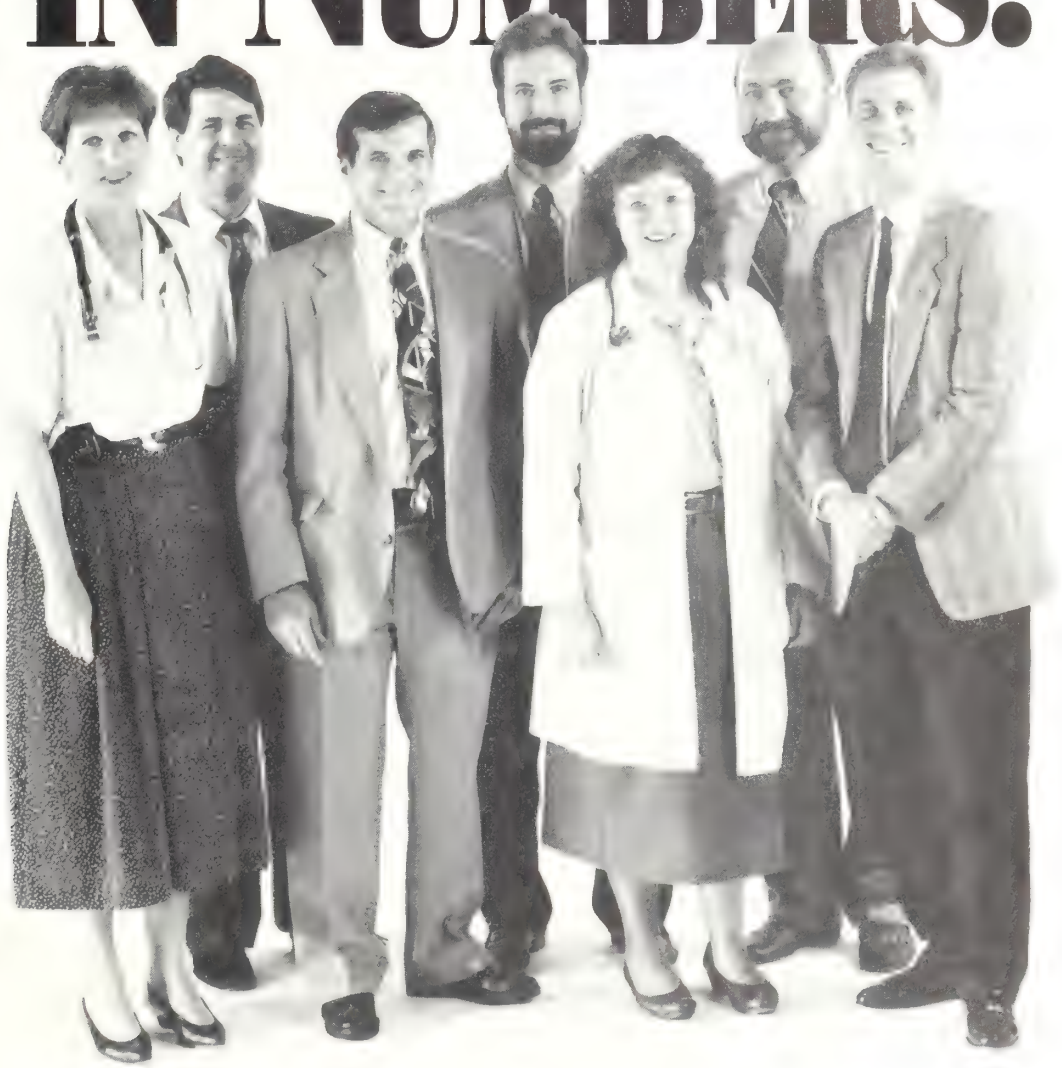
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ISMA, AMA to present program on managed care

The Indiana State Medical Association and the American Medical Association will present "Decisions for Physician Success in the '90s and Beyond," a program for Indiana physicians, Jan. 26 at University Place Conference Center in Indianapolis. The program will focus on managed care, physician organizations and physician hospital organizations.

Speakers at the day-long program will include Nathan Kaufman of The Kaufman Group of San Diego, Calif., a firm specializing in assisting health care providers address the challenges of the new health care delivery system, and Thomas M. Gorey, J.D., president of Physician Hospital Organization Services in Lakewood, Ill.

For more information, call Meg Patton at the ISMA, (317) 261-2060 or 1-800-257-4762.

Physicians urged to enroll in ISMA key contact program

Because health care and medical issues are expected to be critical issues during the 1994 Indiana General Assembly, the ISMA is encouraging physicians to participate in its key contact program. The program helps physicians communicate with their legislators on issues affecting the medical community. Participants in the key contact program agree to contact their federal and state legislators regarding proposed bills. Physicians who register in the program will receive additional valuable information to help them.

To register as a key contact, complete and return the form on page 470 of this magazine or call Debbie Warner at the ISMA, (317) 261-2060 or 1-800-257-4762.

Bookmarks feature 10 questions on health system reform

Bookmarks featuring 10 questions people should be asking about health system reform are available from the ISMA for physicians who wish to distribute them to their patients. The bookmarks are $5 per 100 and available by calling Mary Barnd at the ISMA, (317) 261-2060 or 1-800-257-4762.

Annual ISMA/IMPAC legislative reception scheduled Jan. 12

Physicians will have an opportunity to meet with their legislators to discuss issues of concern to the ISMA and show their appreciation of their efforts during the annual ISMA/IMPAC legislative reception. The event, featuring a "Jungle Fever" theme, will be from 6 to 8:30 p.m. Jan. 12 at the Westin Hotel in downtown Indianapolis. The Highlife Juju Band will provide the music. Invitations will be mailed in December. Those who do not receive an invitation but would like to attend should call Susan Grant at the ISMA, (317) 261-2060 or 1-800-257-4762. ❑

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letters to editor

A response to 'Assisted suicide is 'bad for medicine"

As a practicing anesthesiologist, I read with great interest the interview in the May/June issue of INDIANA MEDICINE titled "Assisted suicide is 'bad for medicine.'" Some have suggested that if assisted suicide is legalized, anesthesiologists may be considered as the effectors of that law because of their abilities to manage the cardiovascular system.[1]

A topic of this importance, involving as it does a very critical end-of-life decision, should be exposed to a vigorous debate and exchange of information so physicians can make informed, rational decisions on physician-assisted suicide. It is in this spirit that my observations, comments and criticisms are offered.

The interview uses the terms "physician-assisted suicide," "suicide" and "euthanasia" interchangeably. They, of course, are not interchangeable. Euthanasia means a good death. The term, in and of itself, does not include a physician's participation. Quoting the article further, "... why our society prohibits killing, homicide and in this case physician-assisted suicide." This statement, by listing the three terms together, suggests to me that they are the same.

My second major concern relates to the views expressed by Dr. Gramelspacher regarding the slippery slope argument in defense of opposition to physician-assisted suicide. The slippery slope argument is subject to considerable weakness because it is liable to be based on two fallacious assumptions. First, the argument presumes that nothing will change as we proceed down the slope – no reasoning will occur, no voices will be raised, no opinions will be changed. In today's world of virtually instant communications and the broadcast media's penchant for probing into every corner, it seems unlikely to me that voluntary euthanasia could lead to involuntary euthanasia. Second, the slippery slope argument inevitably presumes a worst-case scenario. When abortion was legalized, some said the practice would lead to infanticide and the indiscriminate killing of the elderly. The slippery slope argument has not materialized in the abortion scenario and in my opinion will not occur if physician-assisted suicide is legalized.

Third, the article makes statements regarding euthanasia in the Netherlands, especially the figures of "10,000 or even 20,000 people a year die from euthanasia in the Netherlands." This 10,000 to 20,000 figure has been quoted in some of the ethics journals but, to the best of my knowledge, it is little more than speculation.[2]

Finally, Dr. Gramelspacher states on several occasions that he is uncomfortable with the idea of physician-assisted suicide (but strangely enough states that he is comfortable with the principle of double effect). To be sure, each physician must make his/her own decision about physician-assisted suicide in much the same way physicians have decided about abortion. To make the decision, however, available facts and logical arguments should aid in the decision-making process. Central to this process are at least two critical questions that must be answered: 1) What is the proper end of medicine?; and 2) What is the nature of the contract the physician has with the patient?

Regarding the first question, Dr. Gramelspacher's position is understandable if one views the prolongation of life as the only or most basic goal of medicine. Many physicians, however, view the restoration and preservation of health and the reduction of suffering as important goals of medicine and as a corollary recognize a duty to assist the patient by whatever reasonable means the knowing patient may request when restoration of health is no longer possible. "Whatever reasonable means" would include physician-assisted suicide when it is legalized and the knowing patient has made an informed decision in requesting it.

Regarding question two, literally volumes have been written[3] regarding what form a patient-physician relationship may take and the importance of making certain both parties understand the nature of the contract. Implicit in this understanding is the discussion of issues like euthanasia and other end-of-life decisions so the patient may seek another physician's care if the first physician is unable by virtue of his/her moral principles to provide all the care the patient may need at end of life.

End-of-life decisions, among them the option of voluntary euthanasia, are important topics deserving a dialogue involving facts and logical arguments. End-of-life decisions must be based on the broadest possible factual grounding. ❑

References

1. Jonsen AR: To help the dying die – A new duty for anesthesiologists? *Anesthesiology*, 78:225-228, 1993.

2. Fenigsen R: A case against Dutch euthanasia. *Hastings Center Report*, 19(1):22-30, 1989.

3. Brody B: *Life and Death Decision Making*. New York, NY: Oxford University Press; 1988:56-99. Kass LR: *Toward a More Natural Science*. New York, NY: The Free Press; 1985:157-186. Emanuel EJ, Emanuel LL: Four models of the physician-patient

relationship. *JAMA*, 267:2221-2226, 1992.
Veatch RM: *Death, Dying and the Biological Revolution*. New Haven, CT: Yale University Press; 1989:59-88.

Harry L. Keffer, M.D.
Terre Haute

Response from Gregory Gramelspacher, M.D.

I welcome this opportunity to respond to Dr. Keffer's letter. I agree that the subject of physician-assisted suicide is too important not to debate openly and honestly. Nonetheless, even if Dr. Keffer and I could agree on the facts and argue logically, I believe that we would come to different conclusions about the acceptability of physician-assisted suicide. In response, I would like to re-emphasize my two major objections to the practice of either physician-assisted suicide or active voluntary euthanasia. The first objection is based on the great potential for abuse, and the second objection is based on my understanding of what it means to be a physician.

Dr. Keffer criticizes the slippery slope argument because it presumes a worst case scenario. He suggests that the progression from active voluntary euthanasia to involuntary euthanasia is unlikely because media scrutiny will help protect against abuse. However, when we look to the Netherlands, we see the potential for extraordinary abuse.[1] Yet, unlike the Netherlands, our society has done little to guarantee comprehensive long-term care, mental health coverage or ready access to hospice care. In our fragmented health care system, we are struggling with cost containment while trying to expand access and ensure quality. The best numerical argument against physician-assisted suicide is not the disputed number of patients euthanized in the Netherlands each year, but rather the 37 million Americans who are uninsured or underinsured in the United States each day. It is ironic that now, as the United States is considering universal health insurance, one of the "minimum" benefits should be the option of physician-assisted suicide.

Medicine is not a value-neutral enterprise, but rather a profession with ends and goals that include striving for health, curing the sick when possible, and always caring for ill patients who seek help. Trust involves the expectation that others will respect moral limits and rests in the knowledge that medicine has an intrinsically humanitarian end – to cure, to care for and to comfort the sick. In order to retain public trust and maintain our ethical center, we must remain devoted to these goals. Procedural safeguards will not be enough to protect patients from diagnostic error or inadequate treatment. Support for physician-assisted suicide or active voluntary euthanasia acknowledges that we have finally failed in our commitment not to abandon one another.[2] ❑

References

1. Gomez CF: *Regulating Death: Euthanasia and the Case of the Netherlands*. New York, NY: The Free Press; 1991.

2. Hauerwas S: Rational suicide and reasons for living. In: Lammers S, Verhey A, eds. *On Moral Medicine: Theological Perspectives in Medical Ethics*. Grand Rapids, Mich: William B. Eerdmans Publishing Co.; 1987.

Gregory Gramelspacher, M.D.
Indianapolis

Letters to the editor

INDIANA MEDICINE welcomes letters from readers. Please submit double-spaced, typed letters that are limited to 250 words and include your name and address. Letters may be edited for space, style and grammar.

Send your letters to George T. Lukemeyer, M.D., INDIANA MEDICINE, 322 Canal Walk, Indianapolis, IN 46202-3252. ❑

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Robert C. Colvin, M.D.
Newburgh

Indiana State Medical Association

Key Contact Program

Dear ISMA Member:

The ISMA is in the process of expanding and updating its LEGISLATIVE KEY CONTACT PROGRAM to increase involvement with the Indiana General Assembly and Indiana's congressional delegation. The ISMA must continue to increase its physician input into the legislative process at the grass roots level. Lawmakers are asked each year to consider hundreds of legislative proposals that may have impact on the practice of medicine. How lawmakers respond to these issues can be influenced by physician input. LEGISLATIVE KEY CONTACT PHYSICIANS assist the ISMA with various projects designed to enhance the practice of medicine in Indiana.

If you are not already a LEGISLATIVE KEY CONTACT PHYSICIAN and want to become involved, please fill out this form and return it to ISMA. If you already are a LEGISLATIVE KEY CONTACT PHYSICIAN, please fill out this form and drop it in the mail so we can update our lists.

Please list below each Indiana State Senator, Indiana State Representative, U.S. Congressman from Indiana or U.S. Senator from Indiana with whom you are acquainted or whom you would be willing to contact on health/medical issues. Also, please indicate what relationship you have with the lawmaker listed. A previously established relationship is not necessary for participation in the Legislative Key Contact Program.

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In patients with severe congestive heart failure, with or without associated renal insufficiency, excessive hypotension has been observed and may be associated with oliguria and/or progressive azotemia, and rarely with acute renal failure and/or death. Because of the potential fall in blood pressure in these patients, therapy should be started under very close medical supervision. Such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart or cerebrovascular disease, in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given without difficulty once the blood pressure has increased after volume expansion.

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis and/or larynx has been reported in patients treated with angiotensin converting enzyme inhibitors, including enalapril. In such cases VASERETIC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis or larynx, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided.** (See ADVERSE REACTIONS.)

Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see also CONTRAINDICATIONS).

Neutropenia/Agranulocytosis: Another angiotensin converting enzyme inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Lithium generally should not be given with thiazides (see PRECAUTIONS, *Drug Interactions, Enalapril Maleate and Hydrochlorothiazide*).

Pregnancy, Enalapril Hydrochlorothiazide: There was no teratogenicity in rats given up to 90 mg/kg/day of enalapril (150 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose) or in mice given up to 30 mg/kg/day of enalapril (50 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose). At these doses, fetotoxicity expressed as a decrease in average fetal weight occurred in both species. No fetotoxicity occurred at lower doses, 30/10 mg/kg/day of enalapril-hydrochlorothiazide in rats and 10/10 mg/kg/day of enalapril-hydrochlorothiazide in mice.

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC should be discontinued as soon as possible. (See *Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality*, below.)

Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality: ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of VASERETIC as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, VASERETIC should be discontinued unless it is considered lifesaving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Enalapril, which crosses the placenta, has been removed from neonatal circulation by peritoneal dialysis with some clinical benefit, and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

No teratogenic effects of enalapril were seen in studies of pregnant rats and rabbits. On a mg/kg basis, the doses used were up to 333 times (in rats), and 50 times (in rabbits) the maximum recommended human dose.

Hydrochlorothiazide Teratogenic Effects: Reproduction studies in the rabbit, the mouse and the rat at doses up to 100 mg/kg/day (50 times the human dose) showed no evidence of external abnormalities of the fetus due to hydrochlorothiazide. Hydrochlorothiazide given in a two-litter study in rats at doses of 4 - 5.6 mg/kg/day (approximately 1 - 2 times the usual daily human dose) did not impair fertility or produce birth abnormalities in the offspring. Thiazides cross the placental barrier and appear in cord blood.

Nonteratogenic Effects: These may include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

PRECAUTIONS: *General, Enalapril Maleate, Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe congestive heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with angiotensin converting enzyme inhibitors, including enalapril, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20 percent of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent pre-existing renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when enalapril has been given concomitantly with a diuretic. This is more likely to occur in patients with pre-existing renal impairment. Dosage reduction of enalapril and/or discontinuation of the diuretic may be required.

Evaluation of the hypertensive patient should always include assessment of renal function.

Hemodialysis Patients: Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes (e.g., AN 69*) and treated concomitantly with an ACE inhibitor. In these patients consideration should be given to using a different type of dialysis membrane or a different class of antihypertensive agent.

Hyperkalemia: Elevated serum potassium (greater than 5.7 mEq/L) was observed in approximately one percent of hypertensive patients in clinical trials treated with enalapril alone. In most cases these were isolated values which resolved despite continued therapy, although hyperkalemia was a cause of discontinuation of therapy in 0.28 percent of hypertensive patients. Hyperkalemia was less frequent (approximately 0.1 percent) in patients treated with enalapril plus hydrochlorothiazide. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with enalapril. (See *Drug Interactions*.)

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Warning signs or symptoms of fluid and electrolyte imbalance, irrespective of cause, include dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, confusion, seizures, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or after prolonged therapy. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia may cause cardiac arrhythmia and may also sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Because enalapril reduces the production of aldosterone, concomitant therapy with enalapril attenuates the diuretic-induced potassium loss (see *Drug Interactions, Agents Increasing Serum Potassium*).

Although any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease), chloride replacement may be required in the treatment of metabolic alkalosis.

Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

In diabetic patients dosage adjustments of insulin or oral hypoglycemic agents may be required. Hyperglycemia may occur with thiazide diuretics. Thus latent diabetes mellitus may become manifest during thiazide therapy.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

If progressive renal impairment becomes evident consider withholding or discontinuing diuretic therapy.

Thiazides have been shown to increase the urinary excretion of magnesium; this may result in hypomagnesemia.

Thiazides may decrease urinary calcium excretion. Thiazides may cause intermittent and slight elevation of serum calcium in the absence of known disorders of calcium metabolism. Marked hypercalcemia may be evidence of hidden hyperparathyroidism. Thiazides should be discontinued before carrying out tests for parathyroid function.

Increases in cholesterol and triglyceride levels may be associated with thiazide diuretic therapy.

Information for Patients, Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

Pregnancy: Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

NOTE: As with many other drugs, certain advice to patients being treated with VASERETIC is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions, Enalapril Maleate, Hypotension—Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS.)

Agents Causing Renin Release: The antihypertensive effect of enalapril is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: Enalapril has been used concomitantly with beta adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine and prazosin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: Enalapril attenuates diuretic-induced potassium loss. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia they should be used with caution and with frequent monitoring of serum potassium.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant enalapril and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Hydrochlorothiazide: When administered concurrently the following drugs may interact with thiazide diuretics.

Alcohol, barbiturates, or narcotics—potentiation of orthostatic hypotension may occur.

Antidiabetic drugs (oral agents and insulin)—dosage adjustment of the antidiabetic drug may be required.

Other antihypertensive drugs—additive effect or potentiation.

Cholestyramine and colestipol resins—Absorption of hydrochlorothiazide is impaired in the presence of anionic exchange resins. Single doses of either cholestyramine or colestipol resins bind the hydrochlorothiazide and reduce its absorption from the gastrointestinal tract by up to 85 and 43 percent, respectively.

Corticosteroids, ACTH—intensified electrolyte depletion, particularly hypokalemia.

Pressor amines (e.g., norepinephrine)—possible decreased response to pressor amines but not sufficient to preclude their use.

Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarine)—possible increased responsiveness to the muscle relaxant.

Lithium—should not generally be given with diuretics. Diuretic agents reduce the renal clearance of lithium and add a high risk of lithium toxicity. Refer to the package insert for lithium preparations before use of such preparations with VASERETIC.

Non-steroidal Anti-inflammatory Drugs—In some patients, the administration of a non-steroidal anti-inflammatory agent can reduce the diuretic, natriuretic, and antihypertensive effects of loop, potassium-sparing and thiazide diuretics. Therefore, when VASERETIC and non-steroidal anti-inflammatory agents are used concomitantly, the patient should be observed closely to determine if the desired effect of the diuretic is obtained.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Enalapril in combination with hydrochlorothiazide was not mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril-hydrochlorothiazide did not produce DNA single strand breaks in an *in vitro* alkaline elution assay in rat hepatocytes or chromosomal aberrations in an *in vivo* mouse

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bone marrow assay.

Enalapril Maleate: There was no evidence of a tumorigenic effect when enalapril was administered for 106 weeks to rats at doses up to 90 mg/kg/day (150 times* the maximum daily human dose). Enalapril has also been administered for 94 weeks to male and female mice at doses up to 90 and 180 mg/kg/day, respectively, (150 and 300 times* the maximum daily dose for humans) and showed no evidence of carcinogenicity.

Neither enalapril maleate nor the active diacid was mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril was also negative in the following genotoxicity studies: rec-assay, reverse mutation assay with *E. coli*, sister chromatid exchange with cultured mammalian cells, and the micronucleus test with mice, as well as in an *in vivo* cytogenic study using mouse bone marrow.

There were no adverse effects on reproductive performance in male and female rats treated with 10 to 90 mg/kg/day of enalapril.

Hydrochlorothiazide: Two-year feeding studies in mice and rats conducted under the auspices of the National Toxicology Program (NTP) uncovered no evidence of a carcinogenic potential of hydrochlorothiazide in female mice (at doses of up to approximately 600 mg/kg/day) or in male and female rats (at doses of up to approximately 100 mg/kg/day). The NTP, however, found equivocal evidence for hepatocarcinogenicity in male mice.

Hydrochlorothiazide was not genotoxic *in vitro* in the Ames mutagenicity assay of *Salmonella typhimurium* strains TA 98, TA 100, TA 1535, TA 1537, and TA 1538 and in the Chinese Hamster Ovary (CHO) test for chromosomal aberrations, or *in vivo* in assays using mouse germinal cell chromosomes, Chinese hamster bone marrow chromosomes, and the *Drosophila* sex-linked recessive lethal trait gene. Positive test results were obtained only in the *in vitro* CHO Sister Chromatid Exchange (clastogenicity) and in the Mouse Lymphoma Cell (mutagenicity) assays, using concentrations of hydrochlorothiazide from 43 to 1300 µg/mL, and in the *Aspergillus nidulans* non-disjunction assay at an unspecified concentration.

Hydrochlorothiazide had no adverse effects on the fertility of mice and rats of either sex in studies wherein these species were exposed, via their diet, to doses of up to 100 and 4 mg/kg, respectively, prior to conception and throughout gestation.

Pregnancy, Pregnancy Categories C (first trimester) *and D* (second and third trimesters): See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality*.

Nursing Mothers: Enalapril and enalaprilat are detected in human milk in trace amounts. Thiazides do appear in human milk. Because of the potential for serious reactions in nursing infants from either drug, a decision should be made whether to discontinue nursing or to discontinue VASERETIC, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: VASERETIC has been evaluated for safety in more than 1500 patients, including over 300 patients treated for one year or more. In clinical trials with VASERETIC no adverse experiences peculiar to this combination drug have been observed. Adverse experiences that have occurred, have been limited to those that have been previously reported with enalapril or hydrochlorothiazide.

The most frequent clinical adverse experiences in controlled trials were: dizziness (8.6 percent), headache (5.5 percent), fatigue (3.9 percent) and cough (3.5 percent). Adverse experiences occurring in greater than two percent of patients treated with VASERETIC in controlled clinical trials were: muscle cramps (2.7 percent), nausea (2.5 percent), asthenia (2.4 percent), orthostatic effects (2.3 percent), impotence (2.2 percent), and diarrhea (2.1 percent).

Clinical adverse experiences occurring in 0.5 to 2.0 percent of patients in controlled trials included: *Body As A Whole*: Syncope, chest pain, abdominal pain; *Cardiovascular*: Orthostatic hypotension, palpitation, tachycardia; *Digestive*: Vomiting, dyspepsia, constipation, flatulence, dry mouth; *Nervous/Psychiatric*: Insomnia, nervousness, paresthesia, somnolence, vertigo; *Skin*: Pruritus, rash; *Other*: Dyspnea, gout, back pain, arthralgia, diaphoresis, decreased libido, tinnitus, urinary tract infection.

Angioedema: Angioedema has been reported in patients receiving VASERETIC (0.6 percent). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis and/or larynx occurs, treatment with VASERETIC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In clinical trials, adverse effects relating to hypotension occurred as follows: hypotension (0.9 percent), orthostatic hypotension (1.5 percent), other orthostatic effects (2.3 percent). In addition syncope occurred in 1.3 percent of patients. (See WARNINGS.)

Cough: See PRECAUTIONS, *Cough*.

Clinical Laboratory Test Findings, Serum Electrolytes: See PRECAUTIONS.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.6 percent of patients with essential hypertension treated with VASERETIC. More marked increases have been reported in other enalapril experience. Increases are more likely to occur in patients with renal artery stenosis. (See PRECAUTIONS.)

Serum Uric Acid, Glucose, Magnesium, and Calcium: See PRECAUTIONS.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g percent and 1.0 vol percent, respectively) occur frequently in hypertensive patients treated with VASERETIC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1 percent of patients discontinued therapy due to anemia.

Liver Function Tests: Rarely, elevations of liver enzymes and/or serum bilirubin have occurred.

Other adverse reactions that have been reported with the individual components are listed below and, within each category, are in order of decreasing severity.

Enalapril Maleate—Enalapril has been evaluated for safety in more than 10,000 patients. In clinical trials adverse reactions which occurred with enalapril were also seen with VASERETIC. However, since enalapril has been marketed, the following adverse reactions have been reported: *Body As A Whole*: Anaphylactoid reactions (see PRECAUTIONS, *Hemodialysis Patients*), *Cardiovascular*: Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high risk patients (see WARNINGS, *Hypotension*), pulmonary embolism and infarction, pulmonary edema, rhythm disturbances including atrial tachycardia and bradycardia, atrial fibrillation, hypotension, angina pectoris; *Digestive*: Ileus, pancreatitis, hepatic failure, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, anorexia, glossitis, stomatitis, dry mouth; *Hematologic*: Rare cases of neutropenia, thrombocytopenia and bone marrow depression. Hemolytic anemia, including cases of hemolysis in patients with G-6-PD deficiency, has been reported, a causal relationship to enalapril has not been established; *Nervous System/Psychiatric*: Depression, confusion, ataxia, peripheral neuropathy (e.g., paresthesia, dysesthesia); *Urogenital*: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS), flank pain, gynecomastia; *Respiratory*: Pulmonary infiltrates, bronchospasm, pneumonia, bronchitis, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection; *Skin*: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pemphigus, alopecia, flushing, photosensitivity; *Special Senses*: Blurred vision, taste alteration, anosmia, conjunctivitis, dry eyes, tearing.

Miscellaneous: A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia/myositis, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash and other dermatologic manifestations.

Fetal/Neonatal Morbidity and Mortality: See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality*.

Hydrochlorothiazide: *Body as a Whole*: Weakness; *Digestive*: Pancreatitis, jaundice (intrahepatic cholestatic jaundice), sialadenitis, cramping, gastric irritation, anorexia; *Hematologic*: Aplastic anemia, agranulocytosis, leukopenia, hemolytic anemia, thrombocytopenia; *Hypersensitivity*: Purpura, photosensitivity, urticaria, necrotizing angiitis (vasculitis and cutaneous vasculitis), fever, respiratory distress including pneumonitis and pulmonary edema, anaphylactic reactions; *Musculoskeletal*: Muscle spasm; *Nervous System/Psychiatric*: Restlessness; *Renal*: Renal failure, renal dysfunction, interstitial nephritis (see WARNINGS); *Skin*: Erythema multiforme including Stevens-Johnson syndrome, exfoliative dermatitis including toxic epidermal necrolysis, alopecia; *Special Senses*: Transient blurred vision, xanthopsia.

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* Based on patient weight of 50 kg.

For more detailed information, consult your DuPont Pharma Representative or see Prescribing Information.

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Labs limit testing

Bob Carlson
Indianapolis



"Anybody, anywhere, any time, who removes anything from the human body and tests it for the purpose of diagnosing, treating, assessing or prevention is under CLIA and must have a CLIA certificate."

The only exceptions, explains Mary Azbill, are forensic lab work, research labs that do not report patient results and facilities that perform only urine drug testing.

Mary E. Azbill, M.T. (ASCP), is program director in the Division of Acute Care Services at the Indiana State Department of Health. Every state has a contract with the Health Care Financing Administration to perform on-site laboratory inspections and make recommendations for CLIA certification. In Indiana, those responsibilities fall under Azbill's jurisdiction.

As she talks about CLIA (Clinical Laboratory Improvement Amendments of 1988), Azbill smiles the patient smile of someone who has answered these questions before and expects to answer them many more times. According to Azbill, some health care providers are "in denial" about CLIA. "They did not want it. Many still do not feel it's necessary. So [their attitude] is maybe it'll go away," she says.

At the same time, Azbill says she is seeing good plans being submitted by laboratories to remedy deficiencies that were identified during on-site inspections. She and a field staff of five office medical technologists are currently performing about 50 laboratory inspections per month throughout the state. So far, no sanctions have been recommended against any physician laboratories in Indiana.

Azbill is a medical technologist certified by the American Society of Clinical Pathologists. In her current position, she is also responsible for the Medicare and Medicaid laboratory certification programs and is the division supervisor for blood center licensure. From 1975 to 1984, she was with the Indiana University Department of Medicine, Hematology and Oncology. Previously she was a laboratory supervisor, teaching coordinator and special chemistry technologist at The Christ Hospital in Cincinnati. She is a graduate of the University of Kentucky.

Azbill maintains that there is no excuse for physicians not to be informed about CLIA. In this conversation with INDIANA MEDICINE, she answers some of the questions you may have been too busy to ask.

INDIANA MEDICINE: **Why is it necessary to regulate small physician office labs that do simple inexpensive tests?**

Azbill: Because the law and statute speak to it. The law was changed in 1988 because of reports of cholesterol testing where different results were found for the same person, HIV tests that were being performed and reported in error without confirmation, plus *The Wall Street Journal* reports on Pap smears being read incorrectly, and "20/20" reports on women who had hysterectomies who didn't need them and others who died because they should have had surgeries but didn't get them due to errors in Pap testing. Congress researched

as result of CLIA

this through committees in 1988 and found that the government really had no federal jurisdiction over most laboratories nor did it know how many people did testing, who they were or what their qualifications were.

Every state was a little different. Some states like California and New York had very stringent laws. Other states like Indiana had no laws. Hospitals were very highly regulated. Independent laboratories were highly regulated. But for all other lab testing sites – public health labs, doctors' offices, health clinics – there were no regulations, and no one ever looked at them. No one could tell the public, who were now asking questions, how many labs there were or what the quality of lab testing was because no one knew. This was what caused the change in the 1967 requirement from only interstate testing labs to be licensed to mandatory [certification] for all laboratories, regardless of the site of testing. So why is it necessary? To assure quality lab results regardless of where the lab is located or under whose direction it operates.

Most insurance companies and patients pay the same price for a test. Whether it's performed in a doctor's office or a hospital, there's usually a cap on what's paid for a test. It may be inexpensive for a doctor to run a test, but at the same time he gets paid the same amount of money from Medicare as a hospital or someone else. So I'm not sure inexpensive fits into it at all. And some tests that you think are simple are not really that simple. That's why the test classification became the law.

INDIANA MEDICINE: **It seems like overregulation, driving up the cost and putting the solo small practice out of the lab business.**

Azbill: If you look at the CLIA regulations from a laboratory standpoint, they are good laboratory standards of practice. In my opinion, it's not overregulation. What the doctors are looking at as overregulation is the on-site visit and the documentation required to assure that they have done what they said. They say, "You're interrupting me" or "I'm having to write things down that I already know how to do." But that's the inspection process. I can't inspect you and say you're doing it correctly unless I've got something to look at. I can't just take your word for it. There's a liability aspect, too, I would assume. If there were a liability suit, the laboratory standards of practice that CLIA requires would be to their benefit to have documented.

> ***"If there were a liability suit, the laboratory standards of practice that CLIA requires would be to their benefit to have documented."***

There have been a lot of studies done on the cost of CLIA. It has been estimated that about 25 cents a test would be the overall cost increase. It doesn't sound like a lot of money if your test is the one that may be wrong. It does drive up the cost, but I don't know that we've put any small solo practice labs out of business. We may be causing them to look at their practice and say, "Is it cost-effective for me to continue to do this test?" That's what we're seeing. They're not going out of business, but they are adjusting their menu of tests to fit what they feel they need to have quickly and what's going to put them within the range of regulation that they can live with. They're either switching to waived testing, or they're switching to physician-performed microscopic testing. Some are switching from high to moderate [complexity] testing.

INDIANA MEDICINE: **Can the nurse in my office continue to perform the laboratory testing?**

Azbill: It depends again on the type of test you're doing. For the waived complexity test, anybody can do the test, as long as the director of the lab approves it. For physician-performed microscopy, the physician must do the test. For moderate-complexity [testing], there must be documentation of a high school diploma and on-the-job training that shows the person is competent in the tests assigned. I think I'd want whoever was doing my tests to have at least those credentials. If you jump up to high-complexity [testing], by 1997 anyone performing a high-complexity test must have an associate degree in a laboratory science or medical technology. The definition of an associate degree is 60 semester hours, with a certain number of hours in

biology, chemistry and the related sciences. So a nurse with an associate degree in nursing can do high-complexity testing. A nurse with a B.S. degree in nursing can do high-complexity testing. A nurse with a B.S. degree can even direct some labs, without a doctor's supervision, depending on the complexity of the tests. So nothing would indicate that a nurse would not be able to perform testing.

INDIANA MEDICINE: **Does a physician office laboratory have to change the way it is performing laboratory tests?**

Azbill: Not necessarily. The inspector would look at the lab's compliance with the regulation. If the laboratory was performing the test in compliance with the regulation, it wouldn't have to change anything.

What we're finding is much different. The regulation says to follow manufacturer's instructions. Many labs don't even have manufacturer's instructions available to know if they're following them or not. They must have the FDA-approved inserts or instructions that come with the kits or the instrument, and they do have to follow that.



The rules also speak to quality assurance and quality control. Many labs are not running the two levels of quality control required each day. They just don't do it. They weren't told to do it. They didn't know to do it. So if they're not doing that, they would have to change, because the regulation says you must run two levels of known control every day you report patient test results, to assure that the tests you're reporting on the patients are accurate and reliable. If they're in compliance, they wouldn't have to change. If they're not in compliance, they would have to change or stop testing.

INDIANA MEDICINE: **Could you discuss proficiency testing and how it relates to a physician office laboratory?**

Azbill: The regulations speak to previously regulated and not previously regulated. In other words, a physician's office that had never been under Medicare or the previous CLIA '67 regulations is phased in for proficiency. By Jan. 1, 1994, they must enroll in a HCFA-approved proficiency program. There are several of those on the market, and we're beginning to receive the 1994 proficiency programs now available that we expect to be approved by HCFA before January 1994. The College of American Pathologists proficiency program and others have been approved for previous years, and we expect them to be approved in the future.

Enrollment means that the physician has received the information, looked at the testing menu and has chosen a proficiency program approved by HCFA to enroll in, and has subscribed. Three times a year the laboratories will get five specimens on each test that they perform that's a regulated analyte and test these specimens just as if they were a patient's specimen. You can't send them out to another lab. You have to do them yourself. After testing, you send your answers in, and they're graded against other people who do the same test on the same instrument that you do. You have to make 80% or better. You must make 90% in cytology and 100% in immunohematology. All people screening cytology slides eventually will be tested, whenever there's a proficiency program available.

On Jan. 1, 1995, we will begin sanctions for unsuccessful participation, which is failure in two of two or two of three events.

INDIANA MEDICINE: **What happens if an office laboratory fails proficiency testing?**

Azbill: At this point, if they fail, nothing will happen unless we see serious or immediate jeopardy to a patient. Beginning Jan. 1, 1994, we will ask the physician for his or her proficiency results when we do an on-site visit. The proficiency program would have indicated if they failed a specimen or an event, and if they did, they should have taken a corrective action to prevent it from happening again. They should have asked themselves, "Why did I fail?" Sometimes it's as simple as "I put the decimal in the wrong spot" or "I wrote it down wrong

on the form that I sent in." Sometimes it's an error in the dilution of the lipolyzed serum that was sent to them. They have to investigate and figure out why they failed the testing and correct the problems found.

INDIANA MEDICINE: **Do physicians have to have someone from the government inspect their labs or are there independent companies and alternatives?**

Azbill: Physicians have to be CLIA certified, for whatever category of testing they perform. A lab with a certificate of waiver will not be inspected routinely, except in certain instances. We will inspect waived labs only if someone files a complaint on the lab or if they fall in a random number of waived labs, randomly selected by HCFA to see that these labs are performing only waived testing. We will also do the same thing for certificates of physician-performed microscopies. There will not be any routine, biannual inspections of those labs.

For moderate- and high-complexity testing, the inspection is automatic for the certification unless the laboratory indicates to HCFA that it is accredited by an approved accrediting body. In other words, someone that has equal or more stringent standards and HCFA have had a comparative study of those standards and said, "If you're accredited by this group, then we have accepted their standards to be equal or more stringent than ours, so their inspection will suffice."

State inspectors will not do a second inspection unless there's a complaint filed on the lab or if they fall in a certain percentage of validation surveys requested, expected to be 5%. Validation is when the accrediting group would inspect the lab and send the results to HCFA. About 30 days later, the state inspectors would be sent in to do a comparative survey to see that the accrediting body found essentially the same findings as the state would have found had it completed a CLIA inspection. This comparison survey will be used to renew or approve the accrediting groups when reapplying in the future. If their standards are found to be equal or more stringent and their survey process found to be equal by HCFA, then HCFA will deem the accrediting body to survey in lieu of the state agency.

> ***"Physicians have to be CLIA certified, for whatever category of testing they perform. A lab with a certificate of waiver will not be inspected routinely, except in certain instances."***

At this time, there are no approved, deemed bodies for CLIA that have been published in the *Federal Register*. COLA, the Commission on Office Laboratory Accreditation, has verbally been approved, but we haven't seen it in writing. It has to be published in the *Federal Register* before it's regulation. The Joint Commission of Health Care Organizations has applied and is going through the approval process, and the College of American Pathologists also has applied. So someone else could do the inspection if it were an accrediting body approved by HCFA.

INDIANA MEDICINE: **If I'm a physician just beginning practice, how would I know about CLIA and the compliance requirements? Is there a manual you would recommend to assist in the management of this?**

Azbill: The medical schools know about CLIA, and they are hopefully changing their curriculum to incorporate the 20 CEUs needed for a new physician to begin directorship of a laboratory. Physicians will learn about it in medical school and will be able to move right into a practice lab.

There's hardly a medical journal that's not been talking about CLIA, plus the Indiana State Medical Association keeps you updated in its publications. The inspector's guidelines and the regulations themselves can be purchased by ordering them through the National Technical Information Service for about $40. I would highly recommend that labs get a copy of the inspection guidelines. It actually gives you the questions that the inspectors are probably going to ask. There are also the National Committee for Clinical Laboratory Standards publications. There's also *Medical Laboratory Observer*, a free magazine with updates on quality assurance, quality control and laboratory testing. Any physician office can subscribe and get ex-

actly what you have to put in place –charts, papers, everything. They've published a whole series of articles on CLIA.

INDIANA MEDICINE: **Does CLIA apply only to tests on Medicare patients?**

Azbill: CLIA has nothing to do with Medicare patients. The definition is that anybody, anywhere, any time, who removes anything from the human body – a hair, a skin scraping, anything – and tests it, for the purpose of diagnosing treating, assessing or prevention, is under CLIA and must have a CLIA certificate. Medicare won't pay you for lab testing unless you have a CLIA certificate number. To test or be reimbursed, you must have a CLIA certificate based on the complexity of the tests that you do.

INDIANA MEDICINE: **What if the physician decides to do the test and not bill for it? Is that permissible?**

Azbill: No. He is violating the law. To bill or not bill is [the physician's] prerogative. CLIA does not speak to payment. It says if you do a test on a human specimen and get a result and you use that result for other than legal or forensic purposes, you have to hold a CLIA certificate.



INDIANA MEDICINE: **The AMA reports that CLIA '88 may force as many as 4,000 physician office labs to close or eliminate many of the types of tests that they make available to patients, sending patients to higher cost outside labs and sacrificing the speed and convenience that motivated physicians to provide in-office labs in the first place. What are your comments regarding that statement?**

Azbill: I'm not sure how many physicians will choose to alter their testing menus or to close their labs. Some physician laboratories don't define themselves as laboratories. Many times when we call to schedule a survey, physicians say, "I'm not a laboratory, I'm a physician's office." Physicians' offices doing testing are now also laboratories under the new definition. Physicians look at laboratory testing as an extension of their services. A dermatologist told me his microscope is just like a cardiologist's stethoscope, so why should I come in and tell him to clean it? Because the law says I have to see that the microscope is cleaned if it's being used for a laboratory test.

I don't know that physicians would close their labs, but maybe they would limit their testing. Hopefully they are doing the test that's going to help them diagnose and treat the patient. But if they're just doing a test for money or to document a test performed, then hopefully those are the ones they're going to eliminate. That's what we're seeing. The letters from physicians that are coming in after inspection are not saying "I'm closing."

Physicians are changing their menus. If they're doing only one test that puts them in a high-complexity classification and means a lot more regulation, they're going to drop that one test. We're hearing, "I just do that once every year, so I'm going to send that one test out." We're finding that their reagents are outdated because they haven't done it for a year. How proficient are their people if they don't do that test routinely?

Studies have shown that when cardiac patients had prothrombin times and different clotting tests done in doctors' offices who don't do it regularly or do only a small number, their outcome is not as good as when those tests are performed in laboratories that do the tests routinely. Clotting tests are very sensitive. You're dealing in tenths of seconds and if you don't do that very often, your proficiency, your competency in that test, is going to change. Therefore, your treatment may change. You may prescribe a different dose of Coumadin or other drug based on that test result.

I don't think that we're going to put physician laboratories out of business.

Hopefully, we won't see poorer care. We might see a little longer time in getting test results back to physicians. For instance, a patient with a urinary tract infection goes to the physician. It's going to take time for him to do the colony count or the cultures

because it takes time for bugs to grow. The physician is not going to send the patient home with no treatment. He's going to put the patient on an antibiotic. It's going to take about the same amount of time to send the specimen to a reference lab and get a good sensitivity than for him to do the sensitivity in his office. The advantage will be that if the patient still has the symptoms in two or three days, the sensitivity will tell what antibiotic is the best choice for this patient. A larger lab will probably give a better and more accurate test.

So in the long run, is that hurting or helping? I don't know. It's not going to immediately affect the patient in the way the doctor's going to treat. I guess time will tell us that. It does sacrifice speed in many instances. But sometimes speed can give you an inaccurate test result. Like the coagulation test, for instance. Just because I can do it quicker doesn't mean that I've got a good test method or I'm proficient at it. And that's what CLIA's looking at, the competency of the people doing the test. Are they doing it correctly? Are they good at what they do and do they know what they're doing?

INDIANA MEDICINE: **It appears the hardest hit will be those labs in rural areas and urban areas with a high number of low-income patients. Physicians perform the smallest number of tests in those areas, yet bear a large burden for the cost of implementing CLIA. How is HCFA planning to respond to those concerns of access while at the same time assuring quality lab services?**

Several sources available to answer questions on CLIA

Physicians with questions about CLIA regulations can turn to one of the following sources for answers.

- For technical assistance, call the CLIA Inquiry Hotline, (404) 290-5850, or write to CLIA Laboratory Inquiries, P.O. Box 26689, Baltimore, MD 21207-0489.
- The American Medical Association maintains a CLIA hotline, 1-800-AMA-3211.
- For a copy of the *Physician Office Laboratory Guideline and Procedure Manual*, contact the National Committee for Clinical Laboratory Standards, 771 E. Lancaster Ave., Villanova, PA 19085, (215) 525-2435, or fax, (215) 527-8399. The cost is $125.
- For a copy of CLIA regulations from the *Federal Register*, request PB 93154615 from the National Technical Information Services, (703) 487-4650, or rush order, 1-800-553-6847, or write to 5285 Port Royal Road, Springfield, VA 22161. Enclose a check or money order payable to the Superintendent of Documents or send VISA or MasterCard number. The cost is $36.50 for each copy, plus a $3 handling fee. Rush orders are an additional $15.
- For a copy of the CLIA Interpretive Guidelines, request Appendix C of the *State Operations Manual*, transmittal #256, publication number PB-92-146-174. Call 1-800-553-6847 or (703) 487-4650 or write to National Technical Information Services, at the above address. The cost is $39.50.
- To receive a CLIA application, write to HCFA CLIA Program, P.O. Box 26687, Baltimore, MD 21207-0487, or call the CLIA hotline, (410) 290-5850.
- CLIA applications also may be received by calling the Indiana CLIA program office, (317) 633-8495.
- Barbara Walker and Meg Patton at the Indiana State Medical Association, (317) 261-2060 or 1-800-257-4762, are also available to answer questions. ❑

Azbill: We really don't have that many designated rural areas in Indiana. There's a small community hospital or county hospital in every county. Every hospital has a certified laboratory, so you would have access in every county to at least one hospital lab. The one rural health clinic in the state does have a certificate for waived testing because that's the only category of tests they want to do there. You also have large reference labs that run courier services daily throughout the state to pick up specimens from rural physicians.

Turnaround time would be your biggest argument there. If a laboratory doesn't pick up specimens until the end of the day, it's going to take longer getting the result back to the physician, although most of these reference labs have direct terminal access right into the physician's office. If a laboratory picks the test up after your office closes at five o'clock, the results should be in the physician's office the next day over that computer terminal as soon as that test is done.

The physician's prerogative should be to pick a reference lab that's going to give good turnaround time. That should be at the top of his list.

There's also a lot of new bedside testing instruments or point of care testing instruments on the market. One of the best things about CLIA is that this is the first regulation from the federal government that has built into it a means to change as technology changes. We've already seen changes from the original CLIA '88 regulation, and we're going to continue to see that based on the CLIAC Committee, the Clinical Laboratory Improvement Act Committee at CDC. This committee has input from all the different physician groups, from the government, manufacturers, reference labs that have representatives on that committee. If they make recommendations, these regulations can actually be changed.

INDIANA MEDICINE: **What about the future of CLIA?**

Azbill: We really don't know what's going to happen with CLIA. We've heard lots of rumors. We know that the CLIAC Committee has recommended changes. We know that HCFA is determined and plans on going through with the provisions of CLIA as set forth in the regulations. There's a Congressional hearing Nov. 10 on CLIA and where HCFA is on implementation. Along with Clinton's plan, those committees will determine what's going to happen with CLIA. Will it continue on the road of implementation that's now in the regs? Will it go another course? I don't know. We know what we're to do under our HCFA contract, and we have to continue that until we're told otherwise. Our state budget letter for fiscal year 1994 from HCFA states "CLIA activities should continue uninterrupted."

INDIANA MEDICINE: **Do you feel like CLIA is a bargaining chip?**

Azbill: That's what Hillary Clinton said it was, although the initial sponsors of the bill have said it's not going to be used as a bargaining chip. But I think that's what's been told to the AMA. ❑

This interview was conducted by Bob Carlson, a health care communications consultant in Indianapolis.



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Clinton health reform plan promises universal access

President Clinton's plan to overhaul the American health care system guarantees everyone access to health care, a provision that physicians agree is necessary. Physicians are concerned, however, about other aspects of the plan that might jeopardize the physician-patient relationship and believe that patients must come first under any plan adopted.

The health reform proposal, formally presented in a nationally televised speech Sept. 22, will be debated in Congress during the next several months. Organized medicine will be aggressively expressing its views during the debate, offering alternatives to the Clinton plan that will maintain high standards of medical care and limit government intrusion into the physician-patient relationship.

Here are some highlights of the Clinton plan.

Coverage
All U.S. citizens and legal residents must enroll in health insurance plans, which may be purchased through a state/regional health alliance. A large employer, defined as one with more than 5,000 employees, may provide coverage through its own alliance. Government employees, Medicaid beneficiaries and retirees under age 65 also purchase through alliances.

Employer requirement
All employers must pay 80% of the average area premium. Employer contribution is capped at 7.9% of payroll.

National health board
The seven-member board, appointed by the president, oversees the establishment and administration of the new system. Duties include implementing and enforcing the national health spending budget, monitoring compliance of state plans, and interpreting and updating the benefit package.

By Jan. 1, 1997, each state must establish at least one alliance and certify health plans to participate in alliances.

State responsibilities
By Jan. 1, 1997, each state must establish at least one alliance and certify health plans to participate in alliances. States may establish a single-payer health care system complying with the benefit package and cost-sharing requirements, or a single-payer alliance for part of a state.

Health alliances
Alliances act as conduits between health plans and individual purchasers of health insurance coverage, contracting with health plans to provide the required benefit package and providing a simplified, uniform means for individuals to choose between plans.

Alliances must offer three types of coverage: HMO, PPO and fee-for-service. The fee-for-service option must be presented as long as a fee-for-service plan is financially viable in the area, there is sufficient provider interest and sufficient enrollment to sustain a fee-for-service plan. Alliances set the provider fee schedule for each fee-for-service plan, and providers may not balance bill.

Changes in the marketplace would foster a shift to capitated systems. There may be increased economic pressure on physicians to join vertically integrated groups of physicians, hospitals and others and to enter into more formal arrangements with hospitals, health networks or managed care organizations. These groups may have an advantage in negotiating with alliances, rather than having to compete equally in a pluralistic system.

Health plans
Plans must accept all eligible individuals and may not cancel or reduce benefits even for enrollee nonpayment. Pre-existing condition limits and disease-specific exclusions are prohibited.

State laws protecting against managed care abuses are pre-empted, and state laws banning the corporate practice of medicine are pre-empted.

Global budgets/price controls
A national health care budget would be based on the weighted-

average premium for the guaranteed benefit package as a targeted backstop to market action. Budget increases will be tied to the Consumer Price Index.

Spending targets may not be adjusted, except by Congress.

Physician workforce
Within five years, 50% of physicians in training must be in primary care. The Department of Health and Human Services will allocate residency programs based on recommendations of a new national council on graduate medical education. Federal funds would be withheld from teaching hospitals that exceed their allocated number of trainees.

The demand for primary care physicians in health plans would increase. For some non-primary care specialties, there may be insufficient room in the plans to accommodate all who apply.

Liability reform
Attorney's fees for malpractice are limited to 33 1/3% of an award of lower limits if imposed by states. (The 33 1/3% is the typical share of awards that attorneys now receive from their clients.)

The Department of Health and Human Services will establish rules for public access to information in the National Practitioner Data Bank.

State enterprise liability pilot projects will be set up with federal funds.

Medicare reimbursement
The Medicare fee schedule conversion factor would be reduced by 3% in 1996, with primary care services exempt. Volume and intensity would be deleted from the Medicare Volume Performance Standard formula, thereby cutting future Medicare spending limits by more than half. ❑

AMA officials react to Clinton proposal

In a letter sent to all members, American Medical Association officials commented on President Clinton's health system reform plan. Following are excerpts from the letter from Joseph T. Painter, M.D., AMA president; Lonnie R. Bristow, M.D., chair, AMA Board of Trustees; and James S. Todd, M.D., AMA executive vice-president:

"Some provisions in the President's plan are good for patients and are, in part, consistent with long-standing AMA proposals, including universal access to care, a package of benefits for everyone, a mandate for employers to provide health insurance for every employee and significant insurance reform. These changes will lead to increased demand for health care in the near term and will decrease cost shifting and charity care. The AMA has successfully influenced these provisions and the shift of national attention from a single payer system.

"However, we have serious reservations about the president's proposal because it would limit choices by patients and physicians, undermine the quality of medical services and lead to federal control of medical education and the physician workforce. We are troubled by the degree of centralized regulation in a proposal that is intended to be a competitive, market-based approach. Government and corporate intrusion into the relationship between physician and patient could transform doctors from advocates for their patients to simple dispensers of services.

"We are also deeply concerned that the means to finance reform are unclear. While the president proposes rigid spending limits that will also limit resources for patient care, the plan does not consider adequately other major cost-savings areas like liability and antitrust reform." ❑

The Hospital Medical Staff Section 22nd Assembly Meeting December 2 - 6, 1993 Hyatt Regency New Orleans

HMSS representatives won't want to miss this year's AMA-HMSS Interim Assembly Meeting. They will have an opportunity to learn about and discuss with AMA's leadership and staff the details of President Clinton's health care reform proposal as well as AMA's legislative strategy.

HMSS representatives will also be presented with an overview of physician and physician/hospital organizations, including the physician hospital organization, management services organizations, the foundation and physician equity models, and the hospital-affiliated professional corporation.

Review and analysis of President Clinton's Health Care Reform Plan

President Clinton released his new health care reform plan in September. HMSS representatives in this session will hear a full review and analysis of the plan.

Physician Organizations & Hospital Organizations

Henry E Golembesky, MD, director of Integrated Health Systems Practice of American Practices Management and former chief executive officer of UniMed America, will discuss and examine, from a physician's perspective, the advantages and disadvantages of the organizational structures being created in response to federal, state, and business health care reform initiatives. He also will identify the key elements of successful physician and physician/hospital organizations.

Dr Golembesky will be joined by several physicians who currently practice in these structures. They will share their experiences and cite the challenges and opportunities for physicians. HMSS representatives will be able to ask questions of the physician panelists and together explore mechanisms to maintain physician control in the credentialing of network providers, the monitoring and assessment of patient care, and the setting of quality of care standards/outcomes.

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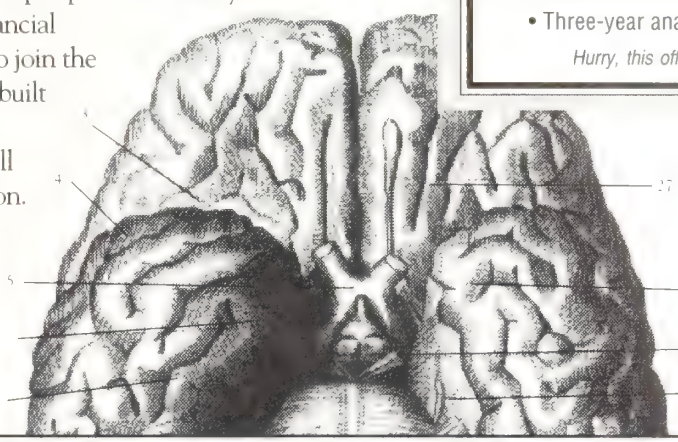
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AIR FORCE

ISMA says Clinton plan will limit care

Editor's note: The following statement is the Indiana State Medical Association's response to President Clinton's health system reform plan.

The Indiana State Medical Association believes that every Hoosier deserves guaranteed access to quality, affordable health care. We appreciate the diligence of the President and Mrs. Clinton in preparation of the health plan. As we enter into the next phase of the debate on health system reform, we will support provisions of the plan that are good for our patients while continuing to address our patients' best interests.

There is good news and bad news in the plan as it has been presented. The good news is that access is promised even if you are sick or jobless. The plan promises coverage as good or better than most have now.

The bad news is the plan assures access, NOT care.

Doctors are concerned that the plan puts economics first and patients – our special interest – second. If economics becomes more important than quality, our patients and their families may suffer. No reform will succeed if it's built around economics and not what patients need. We are further concerned about cuts to the Medicaid and Medicare programs to pay for the health plan. The rigid spending limits the plan calls for cannot but limit care as well.

We are concerned how efficient and effective such a massive plan can be. The devil is in the details, and we have five pounds of detail. The degree of proposed government and corporate intrusion into the relationship between physician and patient is staggering. It is incongruous that within a week of announcing the "reinvention of government" to reduce federal regulations and red tape, the president would unveil an entirely new bureaucracy. At least 50 new health alliances, at least one per state, must be developed and be approved by a National Health Board. The plan establishes a maze of agencies and advisory boards charged with everything from developing practice guidelines to collecting data on Medicare beneficiaries.

This plan clearly ends the "Age of Marcus Welby." The corporatization of medicine takes over. The president's proposal could diminish the physician-patient relationship if it transforms doctors from advocates for their patients to simple allocators of services. While innovation and change have been the hallmarks of medicine in this century, we are afraid that patients are not going to be happy with this degree of depersonalization.

As the debate on the plan and others begins in Congress, we will continue to advocate what is right for our patients. ❑

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ISMA members respond to Clinton health plan

INDIANA MEDICINE asked several ISMA members for their opinion on President Clinton's health system reform proposal. Here are their comments.

"I think universal coverage is an admirable goal. It's very difficult to argue against that. I think that would do a lot of good in our current system.

"The reservation that I have about all of this is I can't believe that the mountain of paperwork that we're in won't become an avalanche under this proposed system.

"I think we've shown that universally covering poor people and elderly people and having the government closely involved has produced systems that are inefficient and very difficult to deal with. It's hard for me to believe that a system covering everybody, again closely run and watched by the government, wouldn't be similarly inefficient and bureaucratic.

"It is still very unclear to me how any of this would be financed without being a tremendous drain on government resources, which we already have from all our other programs."

Thomas A. Barley, M.D.
North Vernon
Internal medicine

"We must acknowledge the fact that we have the finest health care delivery system in the world. With that in mind, it becomes difficult for me to believe that any changes significantly impacting this system imposed by either federal or state government will enhance our delivery of health care. This is based on the fact that many of the problems we see in our system are directly related to increasing government control and intervention into the practice of medicine."

Steve M. Barlow, M.D.
Bedford
Anatomic/clinical pathology

"The dishonesty of President Clinton during his campaign justifies significant skepticism of his health care plan. His reform would be excessively bureaucratic, expensive, cost jobs and raise taxes and thus be economically depressive. It would lower the quality of health care.

"The political strategy for this plan is very well thought out. Its flaws are not lost on Clinton. He expects changes. If his plan passed as proposed, he would promptly veto it!"

Thomas A. Brubaker, M.D.
Munster
Internal medicine

"The health care debate has heated up again in the United States. President and Mrs. Clinton have moved medical care back into the public spotlight. Citizens are once again reporting happiness with the medical methods and results that their doctors provide, but many wish it were less expensive and some want easier access to modern medical care. Those same citizens, our patients, are voters. I am confident they will guide their legislators to reasoned attacks on the real problems without demanding a dismantling of so satisfactory a system.

"Most Indiana physicians shudder when governmental inroads are made in their dealings with their patients. They know that higher costs, more written documentation and less trust will follow. They worry that patient care will suffer. But doctors are doctors, and patients appreciate their efforts. Patients are people, and people are ever more sophisticated economists. They will recognize the impossibility that all could enjoy the same access and extent of medical care as can their Congressmen, without massive increases in insurance premiums or taxes – and it was high premiums and taxes that prompted the new health care debate. They see the inevitability of rationing if costs are to be governmentally controlled – and they don't want governmental rationing. They agree with Dr. Koop that governmental control breeds black markets in health care – and they don't like black markets.

"Our patients need to know their doctors are ready to continue good patient care, whatever program is adopted. Indiana physicians have always cooperated with social and political changes that affected patient care.

"This current debate will be long and sometimes rancorous. But it will be educational for all, and the time spent will allow desirable adjustments, acceptable to most. Our patients, the citizens, will certainly remind their political representatives that high premiums and taxes are the problems exciting them and that a drastic difference in their medical care is certainly unacceptable when its obvious effect will be even higher premiums and/or

higher taxes leading to ever higher budget deficits. Reason will prevail."
Thomas J. Conway, M.D.
Terre Haute
Pediatrics

"If we must have government assume the responsibility for the health care of its citizens, the idealism of the Clinton proposal is commendable. There appears little to criticize with his proposed universal availability, simplicity, etc. However, our past experience with government has been one long on promises and short and often unfair on delivery. In this light, the proposal's implementation will be more important than its outline."
Alvan L. Eller, M.D.
Flora
Family practice

"The principal issue is access to health care and concomitant tort reform. While I believe the access issue regarding coverage has been reasonably well thought out, the limiting factor will be choices and availability of nurses and physicians. Mandated fee caps will likely be used to solve the shortage of primary care physicians, but will ultimately fail as a defined two-tiered delivery system evolves."
Mason Goodman, M.D.
Indianapolis
Pulmonary diseases

"I believe reform will have a very positive impact on physicians. Hopefully, we'll see patients more often for preventive care and less often when they are critical or, even worse, terminal. There is no greater joy in this profession than to be able to find a correctable condition and to know that someone is better because you intervened. If reform increases patient care opportunities, then it will be good for physicians also."
Martha J. Mechei, M.D.
Crown Point
Emergency medicine

"The administration's health reform plan will create an unmanageable bureaucracy that will require expanded regulations that will impress restrictions on patients as well as physicians and all other health care providers. It is a plan that cannot produce, in the foreseeable future, any effective reduction of the total cost of health provision."
Edwin Pontius, M.D.
Indianapolis
Anatomic/clinical pathology ❑

Indianapolis physician has voice in Clinton plan

Ray L. Henderson, M.D., an Indianapolis cardiologist, participated in the nine-month development of the Clinton administration's health system reform proposal. Along with administration policymakers, he attended four meetings of the health system reform task force, representing African-American viewpoints as secretary of the board of trustees of the National Medical Association. In advance of Clinton's nationally televised speech on health reform Sept. 22, Dr. Henderson attended a three-hour White House briefing with Ira Magaziner, the president's senior policy adviser, Sept. 19 and a breakfast for 100 physicians with President Clinton Sept. 20. He provided the following statement in response to the Clinton proposal.

"It is important that organized medicine do more than just participate in the debate; it is important that we shape the debate. We should be advocates for our patients in order to provide them with quality health care. We need to redefine the term 'health care provider.' The term 'provider,' as it is now defined, is much too encompassing and detrimental to the interests of the physicians. To include the economic cost of hospitals, nursing homes, pharmacies and medical equipment under the heading of health care provider distorts the image of the physician as a healer. When we carefully examine the health care budget in most national surveys, only 20 cents out of each dollar is reimbursed to physicians for providing medical care. The contributions of physicians, as well as the reimbursements to physicians, have been distorted by this generalized term 'provider.'

"We must emphasize the importance of the president's plan and support his principles of security, simplicity, savings, choice, quality and responsibility. By

accepting these principles, it does not mean that we endorse them. There are areas that will require close scrutiny and modification. For example, the president's concept of choice is unacceptable. His definition of choice concerns the patient's choice of different medical plans – not the patient's choice of physician. The administration's position on the liberalizing or the elimination of the 'any willing provider' language would cause physicians and their patients much concern. This allows organizations to eliminate certain physicians or groups of physicians and has, in the past, eliminated African-American physicians from participating in many of the health care plans currently enforced. In addition, this ability to exclude certain physicians or groups of physicians also exacts a heavy toll on the majority physicians who are also systematically excluded from preferred networks of physicians, restricting the patient's choice of physician.

"Other concerns include the importance of the states in developing and administering these regional health alliances. 'States' rights' has been an enigma for African-American people who have to forge long legal battles in order to ensure rights. In the new plan that is being considered, states should be given very specific templates on which to operate, allowing only minimal flexibility, especially since this is to be a national health plan.

"As we consider the cost of this plan, it is important that we talk in terms of human cost and needs. Organized medicine should not speak as economists, but as concerned individuals. The outline of the president's plan is a very ambitious blueprint that is obtainable and affordable.

"As this debate winds its way through the halls of Congress, organized medicine should be there, suggesting modifications to improve the plan. This will also allow the American people to feel secure that their interests are being served." ❑

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Delegates adopt ISMA health system reform plan

Editor's note: During its annual meeting in October, the Indiana State Medical Association House of Delegates adopted Resolution 93-40, a health system reform plan developed by the ISMA Health Systems Task Force. For a copy of the entire report, call Debbie Warner at the ISMA, (317) 261-2060 or 1-800-257-4762.

The Indiana State Medical Association believes our nation has the expertise and technology to continue to provide the finest quality health care in the world, and at the same time improve distribution of this health care so that all people can obtain *basic* health services. To reach this goal of universal access, we must commit to preservation of quality, cost containment and protection of freedom of choice for patients and providers.

The ISMA Health Systems Task Force has worked diligently over the past six months to develop a health system reform plan that addresses Indiana's health system and how that system might be changed in order to better serve our state's citizens.

The task force had input from diverse medical perspectives, thanks to the appointments of President William Beeson, M.D., and to the involvement of ISMA's past presidents, who were an invaluable asset. The task force also had input from the leadership of several medical specialty societies.

The following is a summary of the task force report.

Long-range goals

We believe the consumer choice model has attributes that inherently overcome many of the problems in our current system. With need-based subsidies, all persons could gain access to personal ownership of health insurance for a defined, standard benefits package. Personal ownership of insurance immediately solves the problem of portability between jobs and with appropriate cost-sharing has – as a linchpin – built-in cost control measures that minimize the need for government or employer imposed rationing and other external controls.

The ISMA Health Systems Task Force generally endorses a consumer choice model of health system implementation as the ultimate goal.

The ISMA Health Systems Task Force generally endorses a consumer choice model of health system implementation as the ultimate goal. The consumer choice model, which was originally developed by scholars at the Wharton School of Business and The Heritage Foundation, is characterized by:

a) An individual mandate: All heads of households would be required to have coverage of a defined benefits package for themselves and their dependents. A more comprehensive policy could be purchased. The defined benefit package would include patient cost-sharing.

b) Subsidies for low-income households: Graduated government subsidies, in the form of vouchers, would be available to assist low-income individuals in paying their premiums and meeting the patient cost-sharing requirements.

c) Tax system changes: Changes in the federal tax system would replace the current incentives for low patient cost-sharing with incentives for consumers to make cost-effective choices when they purchase coverage. The tax exclusion for employer-funded coverage would be eliminated, and individuals and employers would be entitled to the same deduction for health care expenditures, such as premiums, patient cost-sharing requirements, and non-covered services. Essentially, a health care expenditure would be deductible by whomever made the payment.

d) Freedom of choice: Households would be free to purchase the coverage of their choice. Employees would not be required to purchase their insurance through their employer. Unions, professional associations, churches and other groups could arrange for group coverages for their members. Households could also obtain individual policies directly from insurers and insurance agents. Households would be free to choose whether to participate in a managed care plan.

However, a number of complex parallel issues work against a pure consumer choice model at the state level, especially at this time. Federal tax law changes are necessary for this model to be feasible. In addition, a tax increase would probably be required for a state proposal. Finally, it will take time to change the common misconceptions that employer-based coverage is the best security against uninsurance and that individuals are incapable of making their own coverage and health care choices.

We realize that more than two-thirds of Hoosier lives are now covered through an employer-purchased plan. A precipitous change from employer coverage would likely destroy much of what works in the current system. Therefore, we support, as a first step, a movement toward the consumer choice model by affecting a reform of the federal tax laws to provide a level playing field for individually purchased coverage, and the implementation of the following short-term recommendations:

Short-term reform

We believe that the state can assure universal access in the short term through steps that build upon our current employer-based system and take advantage of strong consumer choice features. We propose that the state undertake the following short-term measures to fill in the coverage gaps and encourage patient cost-consciousness:

1. Defined benefits package – It is our recommendation that the ISMA support legislation in the Indiana General Assembly that would replace Indiana's current insurance mandates with a law that would require all insurers to offer a defined core benefits package such as the package developed by the American Medical Association.

2. Employer-based coverage – We favor a modified employer mandate requiring most employers ("most employers" would need to be defined based on the number of employees on the payroll) to offer group coverage, as they do now, of the defined benefit package for their employees and the dependents of their employees. We need to be extremely careful not to place Indiana industry at a competitive disadvantage while implementing this recommendation. We would also need to provide a phase-in period and state funded subsidies for small employers, such as tax credits and exemptions for new employers (with very stringent criteria for defining "small" and "new" to prevent abuse).

3. Employee premium sharing – Limit the employer's mandated premium share, while allowing employers to pay a higher share if the employer elects to do so as a result of a collective bargaining agreement or other situation. Reduce the employer's mandated premium share for part-time employees.

4. Employee option – Allow employees the option to purchase their own coverage and have their employer make a contribution toward their premium equivalent to what the employer would have otherwise paid for its offered coverage.

5. Single coverage – Make provisions to prevent mandated duplicative coverage of working spouses, such as a requirement that one spouse opt out of the mandated employer-funded coverage.

6. Patient cost-sharing – Include significant patient cost-sharing, that is tax deductible, in the mandated defined benefit package.

7. Gap filling – Provide state-funded, need-based, graduated subsidies to assist employees in paying their premium share for the mandated benefit package and the incorporated patient cost-sharing requirements. Also provide need-based subsidies to assist the unemployed and employees not entitled to employer-funded coverage to purchase coverage of the mandated benefit package and to pay the incorporated patient cost-sharing requirements.

8. Reduce administrative burdens – Physicians and other health providers need to be freed from the overwhelming burdens associated with practicing their art and science. To that end, the ISMA recommends that we formally approach all third-party payers and seek the development of consistent forms (such as the HCFA 1500 form), and seek to make the health care system more administratively efficient.

9. Address overutilization – We believe that, by encouraging private ownership of health insurance with cost-sharing, patients will be more cost-conscious and seek to spend their resources in a prudent fashion.

10. Eliminate excessive charges – As patients gain ownership of their health insurance, we believe that market forces will be free to react in such a way that excessive charges are discouraged and chased out of the market. A method of standardizing the processes that insurance companies use to determine reimbursement for procedures and services

should be developed.

11. Practice parameters – The ISMA supports the development of practice parameters, with the following caveats:

- Practice parameters should be viewed as general guidelines and should allow for local input in their development and for local deviation from the standards where the dynamics of a locality's health care system make the parameter logistically or otherwise unworkable.
- Parameters should be developed by physicians with special expertise in the condition for which the parameter is developed.
- Parameters should be developed to establish the most effective method of diagnosis and treatment of the patient, and not be developed based on the economic implications of the parameter.
- Parameters should not be adopted unless 60% of the physicians in the state whose practices will be affected vote to adopt the parameter, and it must be determined that the parameter will reduce unnecessary use of services and will maintain high quality standards.
- Rapidly developing technology and research place limitations on any attempt to standardize care. To allow for progress, the useful duration of any practice parameter is limited and should be revisited every three years, although changes in the form of amendments could become necessary at any time.

12. Public health – The ISMA believes that no reform plan is complete unless it addresses some of the factors that drive the cost of health care up, factors such as tobacco use, sedentary lifestyles, the abuse of alcohol and other drugs, teen pregnancy and others.

13. Basic freedoms – The ISMA believes that the unique nature of the physician-patient relationship dictates that patients must continue to be allowed to choose their physician. Likewise, physicians should be free to choose their own patients, and physicians should not be forced to limit their practice to one group or one hospital.

14. Risk allocation – The ISMA recommends that the Indiana General Assembly create, within the department of insurance, a system whereby persons who are turned down for health insurance, based on established and standardized criteria, may approach the department and certify their status. The department of insurance would, in turn, assign them to a private insurer. Private insurers would be required to take those Hoosiers who have been assigned to them by the department, which would allocate the persons to private insurers based on the percentage of the market the private insurer enjoys.

15. Guaranteed continuity/renewability – The ISMA recommends that insurers be required to continue and renew policies unless the insured does not pay the premium, or in the case of fraud or misrepresentation. Insurers could not increase premiums excessively for groups or individuals with deteriorating health status or claims experience. The maximum increase would be set at a given percentage, plus any increase in the base price of the premium.

16. Prohibit exclusions for pre-existing conditions – The ISMA recommends that exclusions for pre-existing conditions be prohibited except for a pre-defined and standardized set of exceptions.

17. Premium bands – Insurers could vary premiums by age (setting age apart as a block of business). Premiums could not differ within age/sex categories in a block of business by more than a set percentage. The percentage would be set with input from the insurance industry. Insurers would be limited in their ability to vary premiums across different blocks of business. Blocks of business could not be set based on discriminatory boundaries.

18. Prospective reinsurance – The state would be required to establish a prospective reinsurance program for health insurance. An insurer could obtain optional reinsurance for any group or individual. The primary insurer would be liable for a covered individual's health costs up to a threshold amount. Above the

The ISMA believes that no reform plan is complete unless it addresses some of the factors that drive the cost of health care up, factors such as tobacco use, sedentary lifestyles, the abuse of alcohol and other drugs, teen pregnancy and others.

threshold, the reinsurance program would be responsible for the cost. The program would be funded by reinsurance premiums.

19. Medicaid – The ISMA recommends that, in the long term, Medicaid be reformed into a voucher system that would allow recipients to purchase private insurance and pay patient cost-sharing requirements. In the interim, we recommend that Medicaid take appropriate measures to reduce provider hassles and reimbursement inequities. Addressing this problem will go some distance toward resolving the cost-shifting dilemma that has given rise to discussions of health care price controls.

20. Equitable tax deductions – Individuals should be permitted to deduct their expenses for health care as defined under the defined benefits package, including co-insurance, deductibles and the cost of services that are not covered by their insurance, excluding some elective procedures and expenses.

21. Cap on premium tax deduction – The tax deduction available to employers and individuals for premium payments should be capped at the estimated cost of a basic benefit package with significant patient cost-sharing.

22. Health IRAs – Income invested in a segregated account for future health care and earnings retained in the account should be tax deferrable until withdrawal. Withdrawals for health care expenditures would be tax deductible at the time of withdrawal. Non-health care expenditure withdrawals would be subject to tax and substantial penalties.

23. Funding – The ISMA is aware that many of the recommendations embodied in this document will require funding. While development of creative, innovative and adequate revenue sources is outside the realm of our expertise, we believe that any method of funding should recognize that the health system is designed to serve all of society, so the source of funding should fairly reflect that, and the responsibility for funding the program should not be shouldered disproportionately by any single source. We further believe that, in the long term, these recommendations will actually save money, regardless of how it is funded.

Medical education/manpower

Geographic maldistribution of physicians in Indiana and around the country adds a barrier to quality medical care for many Hoosiers. Part of the solution to this problem requires increased numbers of Indiana University School of Medicine graduates seeking primary care careers and practicing in Indiana underserved areas. IU has already worked to address this situation, and is currently the fourth largest producer of primary care physicians in the nation.

A comprehensive plan will be necessary in order to continue to make progress in this area. Among other things, students from underrepresented geographical areas and minority students must be attracted to medical careers. State and federal governments should support scholarships for minority students, attract students to primary care and maintain a high visibility for primary care among medical students. The health system must be altered in order to decrease the disincentives that drive people away from primary care practices. This includes a decrease in the hassle factor associated with primary care practices. ❑

Medicaid issue fades as legislative concern

Mike Abrams
ISMA Director of Government Relations

The 1993 legislative session was a memorable one. The elements of the session that made it memorable were not always pleasant, but they were certainly notable. Who would have thought, for example, that two Indiana statesmen would engage in a test of bladder strength: If the presiding officer of the senate went to the men's room, the president pro tem, a senator of the opposite party, said he would take over the rostrum, close the voting machine and proceed with Senate business. While a state police officer guarded the podium, Lt. Gov. Frank O'Bannon's staff kept coffee away from him.

Since the special session adjourned June 30, a lot of pundits have worked to assess the winners and losers. Who gained political strength and whose political strength was compromised during the melee that occurred between January and June? The real answer to that question will not be known until Hoosiers go to the ballot box in November 1994 to elect state legislators and statewide office holders. But it is interesting to revisit the major events of the session and, with the benefit of a bit of hindsight, make some "armchair quarterback" assessments of who gained and who lost.

Setting the stage

The stage was set for political confrontation even before the legislative session began. In the fall of 1992, budgeteers were reporting that, thanks largely to an exploding Medicaid budget, the state was heading for some lean economic times, and unless Medicaid spending was controlled, cutbacks in some other areas, such as education, would suffer.

In the final analysis, after all the bickering, backbiting and name-calling, the legislature did very little to/for Medicaid.

Making education an issue was a good tactic, because that brought another big stakeholder into the picture: the teachers union (Indiana State Teachers Association). The math is simple: If you spend too much on Medicaid, you must spend less on the school tuition support formula, which leaves less money for teacher salary increases.

As the session wore on, it became obvious that the Medicaid issue was both dominant and virtually unsolvable. Not only were different parties unable to develop consensus solutions, but people were unable to agree on the size of the problem. Medicaid bureaucrats were stating the size of the budget shortfall at levels much higher than House and Senate Republicans agreed to. And, if the problem is not as severe as the Medicaid agency says it is, then obviously the necessary solution is not as severe.

In the final analysis, after all the bickering, backbiting and name-calling, the legislature did very little to/for Medicaid. Getting there, however, was a different story.

The politics of taxes

No legislative issue is fought harder than the taxing of something. It is useful, therefore, when assessing winners and losers, to look at the politics surrounding the tax proposals.

In looking at how other states have addressed health reform, the Indiana State Medical Association became concerned last fall that some Indiana legislators might propose a sick tax, a tax on those who provide health care to the sick. Early, aggressive efforts by the ISMA helped keep a sick tax on physicians off the legislative table.

In a speech to a joint session of the General Assembly on April 6, Gov. Evan Bayh took off the gloves. The joint session was called so the governor could speak about Medicaid. It is unprecedented for a governor to call a joint session to address a legislative body on a single issue, so Statehouse observers were sure that the announcement would be dramatic.

With uncharacteristically ag-

gressive words, Gov. Bayh proposed to tax hospitals 1% of their gross charges. During the ensuing debate over the hospital tax, hospitals were accused of price gouging and of not bearing their fair share of the responsibility to solve the health care cost dilemma. Gov. Bayh said hospitals are not taxed like other businesses so they should be able to easily withstand the 1% tax. He indicted hospital CEO salaries, and he pointed to hospital capital expansions as examples of waste in the health care system. Ann Delaney, one of Bayh's top political advisers and the state Democratic chairman, joked that if you get sick and need to find the hospital in a small Indiana town, just look for the construction cranes.

During his speech, Bayh told legislators that when the speech was over, legislators would be converged upon by special interests, who would call upon them to defeat the tax. He was right about that. You needed a shoehorn to get another lobbyist in the lobby outside the House chamber following the speech.

Gov. Bayh reportedly went to the House Democratic Caucus and asked them to support the hospital tax, vote it out of the House, and he could deliver the Senate votes to get it passed.

As expected, the Indiana Hospital Association (IHA) used every available resource to fight the tax and, ultimately, led the tax to its grave. The IHA quickly provided data that showed which hospitals would be forced to close if a 1% tax was levied on their gross charges. With only one House Democrat voting against the tax (Rep. Doug Kinser, D-New Castle), it passed the House of



Reps. Sam Turpin (R-Brownsburg) and Brian Bosma (R-Indianapolis) listen to a floor debate during the 1993 Indiana General Assembly.

Representatives and went to the Senate for consideration.

Not only did every House Republican vote against the tax, they enjoyed the opportunity to position themselves as the "no new taxes" party, and they fired salvos at the Democrats for voting in favor of taxing hospitals. Using the IHA data, they noted which hospitals would be forced to close if the tax were enacted. At a news conference, House Republicans set up a wheelchair next to the press table and put a sign on it: "Tax me."

The tax then went to the Republican-controlled Senate, where it met with less success. Not only did the Senate Republicans make sport out of killing the tax, they worked to score political points out of killing it. Further, the Senate Democrats did not warm to the idea. And, amidst much pomp and circumstance, the hospital tax died.

With the demise of the hospital tax, and no real alternatives presenting themselves on April 29, the legislature adjourned, as required by statute after the 61st session day, with no budget. Legislators did not return until June 9, when another alternative looked promising.

Exit hospitals, enter cigarettes

When the legislature adjourned without a state budget, and when the hospital tax died, the governor began to look for other sources of revenue. He proposed that the cigarette tax be increased from 15.5 cents per pack to 33.5 cents per pack. With a House speaker that has traditionally been opposed to higher cigarette taxes, it looked as though the governor had crossed a major hurdle. If he could get the speaker to agree to the tax, he might be able to sway enough other votes to pass it.

So the legislators were called back to Indianapolis for a special session, the governor announcing that special interest lobbyists had killed the hospital tax and, therefore, the cigarette tax would be on the table.

Once again, House Republicans postured with "no new taxes" speeches. House Democrats, led by Rep. Pat Bauer, worked to pass the tax, noting the impact of smoking on health care costs. With universal Republican opposition, House Democrats passed a budget with the cigarette tax in the bill, sending it to the Senate for consideration. Teachers, fearing that lack of any tax increase would result in less tuition support, showed up at the Statehouse wearing buttons announcing their support for a tax on cigarettes. The bill might as well have contained a tax on legislators because Senate Republicans, like their House counterparts, took great joy in killing the tax and making "no new taxes" speeches.

What do we do now?
With no new revenue raisers in the budget, the big question of the session became: Where do we go from here? If we do not raise taxes, how do we cost contain so the budget is balanced?

Although you wouldn't know it based on the debate, the big stakeholder in how this question was answered was the Indiana State Teachers Association. At the beginning of the regular session, the teachers union sought a large increase in tuition support. Tuition support is sent to each individual school corporation, and the level of tuition support provided by the General Assembly typically indicates the amount of salary increase that teachers across the state will receive. In January, it appeared that tuition support would increase by only 2%. When the budget passed the House Ways and Means Committee, tuition support was set at a 3% increase. At the end of the regular session, the budget called for a 3.3% increase. During the special session, it was bumped up to 4%. Ultimately, the increase settled at 3.3%.

But with no new revenue raisers in the budget and House Democrats twice voting to increase taxes, only to have the Senate Republicans kill the taxes and criticize Democrats in the process, the House Democrats appeared to lose their incentive to look for new sources of revenue.

By late June, legislators were exhausted, frustrated, homesick, angry and ready to pass a budget, almost any budget, and go home. They were being criticized in their hometown media for not doing their jobs on time. Some legislators, in order to stave off criticism, held news conferences announcing that they would not accept their special session per diem or that they would give their per diem to a charity.

Ed Feigenbaum, who publishes a Statehouse newsletter, reported that the governor had gone to the House Democratic Caucus meeting and asked that the House Democrats stand strong with him and not pass the budget that had been passed by the Senate. Feigenbaum reported that after an impassioned plea by the governor, Speaker Phillips told the governor he could no longer count on the House Democrats to support him. Phillips allegedly told the governor that, after having twice voted for tax increases that failed in the Senate, House Democrats were ready to pass a budget and override a veto if necessary.

On June 30, that is what happened. The House and Senate adopted the budget and, after Bayh vetoed it, the veto was overridden by both chambers, and the budget became law.

Extraneous issues make the point
At the beginning of session, everyone watching the legislature noted that Medicaid was the biggest issue that legislators would wrestle with. In the end, two other issues, very diverse but very important, created the impasse and dislodged the gridlock: tuition support and casino gambling.

Some legislators who would have been predicted to vote against the budget voted for it because it included casino gambling language. Those who had tried for years to get casino gambling with no success believed this was their only chance to see casino legislation pass in Indiana. If not now, never, they felt.

And many who debated the budget behind closed doors in the waning hours of session reported that the word "Medicaid" was rarely spoken. In fact, the hangup was often tuition support and how state funding would be sent to local school corporations. In the end, very little language was adopted that changed the administration of Medicaid.

Different spin doctors say different things about who won and who lost during the 1993 sessions. Many said the governor lost some political standing. But the governor is now forced to deal with a budget that he vetoed. As difficult decisions present themselves to the governor, he has a rock solid defense when constituents get angry: The budget the legislature sent me, over my veto, is forcing me to do this. I don't like it any more than you. ❑

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Digest of health and medical laws

1993 Indiana General Assembly

The 1993 legislative session saw plenty of controversy from start to finish. Health care and Medicaid reform were thrust into the spotlight as it became clear that Indiana would experience a Medicaid funding shortfall over the next biennium unless something in the state's Medicaid program changed. Gov. Evan Bayh made political history by calling the state's first ever joint session of the legislature for a purpose other than the annual State of the State Address when he spoke to the General Assembly about his proposals for solving the Medicaid crisis.

Health care was not the only issue debated; on the contrary, legislators introduced 916 House bills and 657 Senate bills this session. But as is typical of the General Assembly, political differences and time crunches prevented all but 171 House bills and 107 Senate bills from making their way to the governor's desk to become law. The governor vetoed only three acts during the regular session, and one of those was overridden.

However, that was not the end of the General Assembly's labor for the year. Legislators were not able to reach any sort of compromise on either the budget or the Medicaid dilemma during the regular session and so were forced to return to Indianapolis in June for a special session.

The *Digest of Health and Medical Laws* will be helpful to you as you consider the changes in state policies that will impact your practice. While this document does not provide detail on each of the new laws, it will serve as a useful tool. For additional information about the statutes in this book, call the ISMA Government Relations staff at 1-800-257-4762 or (317) 261-2060.

Michael D. Abrams
Director of Government Relations

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House enrolled acts

All new laws are effective July 1, 1993, unless otherwise noted.

HEA 1001 (special session)
- Author: Bauer
- Sponsor: Thompson
- Requires insurance policies that cover drugs to cover cancer treatment drugs regardless of whether they are FDA approved as long as published clinical studies show them to be safe and effective.

HEA 1034
- Authors: Day, Goble, Bayliff
- Sponsors: Johnson, Gery, Craycraft
- Establishes the local health maintenance fund to be used for local boards of health to provide public health services, including animal and vector control, disease control (including immunizations), food sanitation, environmental health, health education, laboratory services, maternal and child health services, nutrition services, public health nursing and vital records (this section is effective June 30, 1993);
- requires school corporations to implement a school breakfast program; and
- requires the department of education to assist schools with the implementation of these programs and apply for federal financial assistance on behalf of the participating school corporations.

HEA 1108
- Authors: Bayliff, Day, Brown
- Sponsors: Leising, Gery
- Requires the state department of health to charge an additional $2 fee per birth certificate;
- requires the state department of health to establish a birth problems registry;
- requires physicians, nurse midwives, local health departments and hospitals to report each confirmed case of a birth problem to the registry not later than 60 days after the birth;
- defines birth problem as one or more of the following: a structural deformation; a developmental malformation; a genetic, inherited or biomedical disease; birth weight of less than 2,500 grams; a condition of a chronic nature, including central nervous system (CNS) hemorrhage or infection of the CNS, that may result in the need for long-term health care; and stillbirth;
- permits the release of additional medical information regarding an adoptee if ordered by a court; and
- allows the health care provider to charge a reasonable fee for the records.

HEA 1218
- Authors: Mannweiler, Kruzan, Friend, Tincher
- Sponsors: Lubbers, Merritt, Doll, Wolf, K. Smith
- Requires a physician or administrator of a hospital or outpatient surgical center to report to the state department of health, within 72 hours, that a person has been treated for a dog bite.

HEA 1223
- Authors: Crosby, Fry, Beck
- Sponsors: Lubbers, Merritt, Doll, Wolf, K. Smith
- Expands the role of the long-term care ombudsman to include the investigation and resolution of complaints and concerns regarding the health, safety, welfare or rights of residents in long-term care facilities;
- the ombudsman must be provided access, with the consent of the patient, to the patient's medical, financial and social records; and
- makes retaliation against a person who files a complaint a Class B misdemeanor.

HEA 1234
- Authors: Wilson, Brown, Cottey, Burton
- Sponsors: Gard, Leising, Hunt
- Requires a pharmacist to place the following statement on the label of each generic drug prescription: "_____ Generic for _____" with the generic name and the brand name inserted on the blank lines.

HEA 1388
- Authors: Gregg, Sturtz, Liggett
- Sponsor: Soards
- Makes the abuse of a corpse by mutilation or sexually deviate conduct a Class D felony. (This does not apply to scientific, medical, historical, forensic or investigative procedures or to funeral directors, embalmers or their employees who are acting within their normal scope of practice and employment.)

HEA 1407
- Authors: Wilson, Dobis, Cottey, McConnell
- Sponsors: Harrison, Hellmann, Hume
- Allows a court that grants an individual probationary driving privileges to include the requirement that the vehicle be equipped with a functioning certified ignition interlock device.

HEA 1514
- Authors: Gregg, Henderson, Dickinson
- Sponsors: Miller, Simpson
- Requires each school to keep an accurate immunization record of its students;
- when a student transfers to another school or enrolls in a post-secondary institution, the school from which the student transfers or graduates may furnish a copy of the student's immunization record to the student's new school;

- allows the state department of health to expand or modify the list of communicable diseases that require documentation of immunity as information warranting such an expansion or modification becomes available; and
- requires documented immunity from diphtheria, tetanus, measles, mumps and rubella for permission to matriculate in a residential campus of a post-secondary institution.

HEA 1564
- Authors: Kinser, Becker, Scholer, Brown
- Sponsors: Miller, K. Smith
- Defines advance practice nurse as a nurse practitioner, nurse midwife or clinical nurse specialist;
- allows the nursing board and the medical licensing board to establish rules regarding the educational requirements for nurses in advanced practice;
- allows the nursing board and the medical licensing board to establish rules regarding the prescription of legend drugs by nurses in advanced practice; and
- requires an advance practice nurse to work in collaboration with a licensed practitioner.

HEA 1595
- Authors: Klinker, J.R. Davis, Stephan
- Sponsors: Meeks, Bray, Breaux, Zakas, Wolf, K. Smith
- Changes the funding mechanism of the drug-free communities' plan to allow the fiscal body to allocate 25% of the money in ways they deem to be appropriate.

HEA 1650
- Authors: Kearns, Kruzan, Day, Budak
- Sponsors: Miller, Riegsecker, K. Smith
- Requires the division of family and children of the family and social services administration to prepare a report to the general assembly regarding the division's management of child abuse and neglect cases;
- creates the child abuse registry;
- requires each local child protection service to have a "child abuse hotline" to respond to calls reporting suspected child abuse (the hotline must be answered 24 hours a day, 7 days a week); and
- every time a substantiated report of child abuse or neglect occurs, the court shall enter the information into the child abuse registry.

HEA 1750
- Authors: Robbins, Grubb, Henderson, Cook
- Sponsors: Leising, Hellmann
- Allows hospitals and fire departments to operate a helicopter landing site without state certification as long as the hospital or fire department regularly receives less than one helicopter during seven consecutive days.

HEA 1768
- Authors: Brown, Becker
- Sponsors: Miller, Simpson, Breaux
- Creates not more than four sub-acute stabilization programs statewide, which each serve between four and 15 individuals, to provide services to the mentally ill on a short-term basis;
- an individual is eligible for services if the attending physician indicates that it is not necessary for the individual to receive acute care inpatient treatment and that the individual is in need of short-term stabilization services; and
- the division of mental health shall report to the legislature regarding the implementation of this act on or before Nov. 1, 1995.

HEA 1798
- Author: Gregg
- Sponsor: Miller
- Allows the executive board of the state department of health, rather than the health facilities council, to promulgate rules regulating health care facilities.

Senate enrolled acts

All new laws are effective July 1, 1993, unless otherwise noted.

SEA 1 (special session)
- Author: Mills
- Sponsor: Bauer
- Provides that the Medicaid office must ensure that provider reimbursement is consistent with efficiency, economy and quality of care and must be sufficient to enlist enough providers so care and services are available under Medicaid, at least to the extent that such care and services are available to the general population in the geographic area.

SEA 49
- Authors: Bray, Alexa, Landske
- Sponsors: Villalpando, Cottey, Wenger
- Requires a child to undergo an HIV screening test if the child has committed a delinquent act that, if committed by an adult, would be a sex crime or a crime involving the use of drugs or drug paraphernalia with an epidemiologically demonstrated risk of transmission of HIV to another person;
- requires the state department of health to notify victims of the above crimes of the child's HIV screening results; and
- requires the state department of health to provide counseling regarding HIV and a referral for appropriate health care to the victims.

SEA 108
- Authors: Riegsecker, Leising, Landske, G. Howard, K. Smith, Johnson, Zakas
- Sponsors: Klinker, Becker, Bosma, Day
- Establishes the family support program to develop a family support policy state plan for the support of people with disabilities and families of people with disabilities, including children with special health care needs or emotional disorders; and
- requires the office of the secretary of family and social services to submit an annual report to the governor and the general assembly before July 1, 1994, and before July 1, 1995.

SEA 174
- Authors: Server, McCarty, Worman
- Sponsors: Dobis, Becker, Heeke, Roorda
- Establishes the Indiana athletic trainers certification board with the health professions bureau; and
- defines "athletic training" as the practice of prevention, recognition, assessment, management, treatment, disposition and reconditioning of athletic injuries under the direction of a licensed team medical doctor, osteopath, podiatrist or chiropractor.

SEA 233
- Authors: Miller, K. Smith, Wolf
- Sponsors: Kinser, Brown, Bales, Wenger
- Creates the physician assistant committee of the medical licensing board;
- permits a physician to supervise two physician assistants; and
- permits the medical licensing board to promulgate rules regarding the appropriate use of prescription drugs by physician assistants.

SEA 283
- Authors: Leising, Alexa
- Sponsors: Klinker, Becker
- Adds home health agency to the list of facilities in which a person may use the title "social services designee" if the person is not certified as a social worker.

SEA 284
- Authors: Leising, Craycraft, Breaux, G. Howard
- Sponsors: Robertson, Warner, Goble, Robbins
- Requires each high school to include instructions regarding the human organ donor program in its health education curriculum; and
- requires the department of education to work with the department of health to develop the necessary educational materials.

SEA 336
- Authors: Worman, Bowser
- Sponsor: Fry
- Removes the regulation of podiatrists from the medical licensing board and creates the board of podiatric medicine; and
- permits a podiatrist to amputate an entire toe if the amputation is performed at an institution that is approved by a joint commission of accredited hospital organization and where co-management of the patient is being performed by a physician.

SEA 356
- Authors: Sinks, Mrvan, G. Howard
- Sponsors: V. Smith, Klinker, Crosby, Scholer
- Requires each blind student in the state to undergo a literacy assessment and, unless it is determined that another media is more appropriate for a blind student, the blind student shall be provided with braille instruction as part of the blind student's individualized education program; and
- as part of the deliberations for appropriate literacy education for a blind student, information about potential reading and writing media options, including braille, shall be provided to parents and the student.

SEA 386
- Authors: Miller, Riegsecker, Wolf, Server, Simpson, Doll
- Sponsors: Kinser, Brown, Becker
- Updates the definition of surgery to include lasers and ionizing radiation.

SEA 389
- Authors: Thompson, McCarty, Randolph, Simpson, Gard, Johnson, G. Howard, Server, Bray, Wheeler
- Sponsors: Tincher, Becker, Cook, J.L. Davis
- Establishes the coroners training board to set standards for the continuing education and training of county coroners and deputy coroners;
- requires local health departments to charge an additional $1 fee for death certificates;
- requires eye enucleators and corneal excision technicians to be registered by the board; and
- if an autopsy is required for a decedent, the coroner may authorize the removal of one or both of the decedent's corneas for donation to an eye bank for transplantation, if the following conditions exist: the corneas are not needed to complete the autopsy or for evidence, the removal will not alter the decedent's facial appearance, the eye bank makes a reasonable attempt to contact the decedent's relatives to inform them of the removal, and there is no known objection to the removal by the decedent or the decedent's relatives.

SEA 410
- Authors: Server, K. Smith
- Sponsors: Crosby, Bayliff
- Changes the regulation of psychologists from certification to licensure; and
- prohibits psychologists from prescribing.

SEA 477
- Authors: Zakas, L. Hume, Leising, Craycraft, Johnson, Mrvan, Worman, Wolf, Miller, R.D. Young, Wyss, Antich, Nugent, Alexa, Bray, Randolph, Adams
- Sponsors: Dvorak, D.A. Young, Villalpando, Pool
- Makes assisted suicide a Class C felony (this includes providing the physical means or participating in a physical act by which another person attempts or commits suicide); and
- establishes the assisted suicide issues study committee, composed of legislators, physicians and non-physicians, that will consider issues concerning and related to assisted suicide.

1993 legislative morgue

The following is a partial list of bills that did not pass during this year's legislative session.

House Bill 1053
- Author: R. E. Hayes
- Digest: Would have allowed a person to indicate in a living will whether to withhold nutrition and hydration in the event that the person is afflicted with a terminal condition.

House Bill 1055
- Author: Villalpando
- Digest: Sought to provide that certain relatives of a decedent could recover damages in a wrongful death action including, but not limited to, medical, hospital, funeral and burial expenses (and lost earnings if the relatives had a reasonable expectation of such a benefit).

House Bill 1093
- Author: Kruse
- Digest: Sought to forbid the possession of tobacco by people younger than 18.

House Bill 1182
- Author: Kearns
- Digest: Sought to require that a health care practitioner who is making a referral to a health care facility in which the practitioner has a significant financial interest must provide the patient with written or oral disclosure of the financial interest and allow the patient the option of receiving the services elsewhere.

House Bill 1222
- Author: Crosby
- Digest: Sought to limit what information a provider may disclose from a patient's mental health record to an insurer upon the patient's consent to the release of information and request for a provider to submit a bill to the insurer. (This prohibits the provider from disclosing case notes, etc., without the further consent of the patient.)

House Bill 1263
- Author: Grubb
- Digest: Sought to require the Indiana University Medical School to guarantee at least four admission openings per year to people who are from rural areas and who agree to practice in a medically underserved area for at least four years after graduation.

House Bill 1273
- Author: Brown
- Digest: Would have created a universal health insurance plan for Indiana.

House Bill 1320
- Author: Crawford
- Digest: Sought to allow, rather than require, a medical review panel opinion to be admitted as evidence at the discretion of the trial court.

House Bill 1341
- Author: Denbo
- Digest: Would have allowed a physical therapist to treat a patient without an order or referral from a licensed physician, podiatrist, psychologist, chiropractor or dentist.

House Bill 1451
- Author: Klinker
- Digest: Sought to provide for the certification of professional counselors and clinical mental health counselors.

House Bill 1455
- Author: Tincher
- Digest: Would have allowed the worker's compensation board, composed entirely of attorneys, to adopt fee schedules for certain medical services.

House Bill 1499
- Author: Crawford
- Digest: Sought to require periodic blood lead testing of all children between 6 months and 6 years of age. (This would also be covered by Medicaid.) Proof of lead testing would be required upon admission to child care facilities and upon enrollment in school. Required the state department of health to establish a lead poisoning screening program, locate problem areas and coordinate lead exposure abatement.

House Bill 1508
- Author: Grubb
- Digest: Would have required the state department of health to set up a voluntary HIV testing program. Hospitals participating in this program would ask admitted patients whether they would like the test performed along with routine admission lab tests.

House Bill 1537
- Author: Kromkowski
- Digest: Sought to forbid discrimination by county hospitals of any practitioner (including a chiropractor or other non-physician) who wants privileges and access to hospital facilities in the treatment of patients when that treatment falls within the practitioner's scope of practice.

House Bill 1593
- Author: Klinker
- Digest: Would have set up licensure procedures for dieticians and nutritionists.

House Bill 1675
- Author: Tincher
- Digest: Sought to indefinitely extend the triplicate prescription program.

House Bill 1766
- Author: Goble
- Digest: Sought to require that a physician may not make a determination that a procedure that has been provided to a patient or is proposed to be provided to a patient is medically unnecessary unless the physician has personally examined the patient.

House Bill 1800
- Authors: Gregg, Kinser
- Digest: Would have allowed hospitals to enter into cooperative agreements if the probable benefits resulting from the agreements outweigh the probable disadvantages attributable to a reduction in competition that may result from the agreements (e.g., if the agreements would help control health care costs, improve access or reduce duplication of services).

House Bill 1801
- Author: Kruzan
- Digest: Would have allowed a court to order a person to undergo an HIV screening test if the person has been arrested for an alleged rape and either refuses to voluntarily submit to the test as requested by the alleged victim or if the court finds probable cause that the alleged rape involved transmission of bodily fluids.

House Bill 1803
- Author: Crawford
- Digest: Would have eliminated the discount given to cigarette distributors. (Current law allows distributors 4% of the cigarette tax as compensation for labor and expenses.) This 4% of the cigarette tax would instead be used to set up a vaccine replacement program to be administered by the state department of health. Any remaining part of that money would be used to establish community health centers.

House Bill 1910
- Author: Alevizos
- Digest: Would have created a health insurance consumer counselor within the department of insurance to investigate complaints from policyholders about the administration of health insurance policies and to order the payment of benefits that were wrongfully denied.

Senate Bill 1
- Authors: Wyss, Alexa
- Digest: Sought to make possession or consumption of an open alcoholic beverage while in a motor vehicle being operated on a public highway illegal. The driver of the motor vehicle also would have been subject to penalty.

Senate Bill 3
- Author: Wyss
- Digest: Sought to reduce the percentage of alcohol by weight in a person's blood from 0.10% to 0.08% that is necessary to constitute prima facie evidence of intoxication for operating a motor vehicle or watercraft.

Senate Bill 119
- Author: Mrvan
- Digest: Would have provided that under worker's compensation and occupational diseases compensation, an employer must furnish the physician of an employee's choice from an approved list by the worker's compensation board.

Senate Bill 151
- Author: Alexa
- Digest: Would have provided licensure for acupuncturists.

Senate Bill 172
- Author: Server
- Digest: Would have provided certification for hypnotists.

Senate Bill 189
- Author: Thompson
- Digest: Sought to grant civil and criminal immunity to physicians for prescriptions written by an optometrist without the oral or written authorization of the physician.

Senate Bill 238
- Author: Riegsecker
- Digest: Sought to require optometrists to consult with (rather than simply notify) a patient's physician before the optometrist could dependently prescribe legend drugs designated as dependently prescribed legend drugs in the optometric legend drug formulary.

Senate Bill 269
- Author: Mrvan
- Digest: Sought to grant civil immunity to a physician who in good faith renders professional services to a pregnant woman under a community health care program.

Senate Bill 273
- Author: Mrvan
- Digest: Would have required a hospital with at least 100 beds to have on duty at all times a physician serving nonemergency patients exclusively, in addition to any emergency room physicians on duty.

Senate Bill 431
- Author: Miller
- Digest: Would have allowed insurers to establish a preferred provider network with primary care case management. Insurers could discriminate based on price, quality, patient access, services rendered and utilization.

Senate Bill 451
- Authors: Miller, Breaux
- Digest: Would have required blood centers to explain information regarding the testing of blood for HIV. A physician ordering a blood transfusion for a patient must obtain informed consent from the patient or the patient's representative, except in an emergency, and provide the appropriate information to make informed consent possible.

Senate Bill 504
- Author: Miller
- Digest: Would have created an electronic data transfer system of prescription monitoring.

Senate Bill 505
- Authors: Miller, Simpson
- Digest: Sought to establish a tuition abatement program for medical students who will practice for four years in a medically underserved area of Indiana following their residencies. Would have required the payment or denial of all Medicaid claims within 30 days of submission. In case of denial, the provider would have had to be given clear and concise reasons for the denial by Medicaid.

Senate Bill 506
- Author: Miller
- Digest: Would have required correctional facilities to periodically test inmates for HIV.

Senate Bill 514
- Authors: Meeks, Doll
- Digest: Sought to authorize employers to set up medical savings accounts under their employees' health insurance policies into which tax-exempt income for the employee could be deposited. This account would be used to pay the medical expenses incurred by the employee.

Senate Bill 525
- Authors: Weatherwax, Soards
- Digest: Would have prohibited drivers from operating a truck on a public highway while a person younger than 18 years of age is in the open bed of the truck unless the child is in an attached seat and secured by a seat belt.

Senate Bill 546
- Author: Server
- Digest: Would have required those who conduct routine mass health screenings to register with the state department of health.

Senate Bill 583
- Author: Adams
- Digest: Sought to limit the portion of the plaintiff's attorney's fees calculated as a percentage of total damages awarded against the health care provider to no more than 25% of the amount actually recovered in a medical malpractice case.

Senate Bill 636
- Author: Sinks
- Digest: Sought to prohibit corporal punishment and encourage alternate methods of discipline in public schools.

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Limited liability company new option for physicians

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Indiana physicians now have an alternative to structuring their practice groups as partnerships or professional corporations. This new business structure, called the limited liability company (LLC), has many features that physicians and physician practice groups may like.

An LLC is a comparatively new form of business organization in the United States that combines the favorable traits of partnerships and corporations. Like a partnership, an LLC may qualify for favorable tax treatment, with income taxed at the individual owner level but not at the entity level. Like a corporation, an LLC provides individual owners with limited liability similar to shareholders.

Use by physicians

Effective July 1, 1993, the Indiana Business Flexibility Act authorizes LLCs to be organized under Indiana law to carry on any lawful business. The act allows physicians to use the LLC alternative for their practices, if the appropriate regulatory agencies permit such use. The Medical Licensing Board (MLB) has determined that it will not need to take any regulatory action for physicians to operate their practices through LLCs. Furthermore, unlike professional corporations, it appears that the MLB will not impose any filing requirements over and above the requirement that articles of organization be filed with the Secretary of State.

Like a professional corporation, an LLC offers physicians more protection from liability than a partnership does. Physicians now practicing in partnership form can avoid personal liability for claims asserted against their partnership or their partners if they reorganize as an LLC. In such cases, the LLC and any negligent professional would still be liable, but non-negligent members would have the same type of limited liability afforded to shareholders of a corporation. It is also possible to protect members and employees of LLCs against some liabilities by creating rights to indemnity from the LLC similar to the indemnity rights of corporate directors and officers.

Like a professional corporation, an LLC offers physicians more protection from liability than a partnership does.

Tax treatment

One of the principal advantages of practicing through an LLC is that, if structured properly, an LLC will qualify for classification as a partnership for tax purposes. This means that only the members of the LLC will be taxed on their share of the income of the LLC. The LLC as an entity will not be taxed.

Many of the act's provisions are "default" provisions, intended to assure classification as a partnership for tax purposes. These default provisions can be varied by the terms of an operating agreement, similar to a partnership agreement for a partnership or bylaws for a corporation, that is approved by the members.

However, varying the default provisions can affect whether the LLC will be classified as a partnership for tax purposes. Physicians should consult with their advisers when forming an LLC to assure that the structure maximizes the tax and other favorable aspects that an LLC can offer.

Formation of LLC

An LLC is formed by filing articles of organization with the Secretary of State. The act requires only minimal information to be included in this public filing. For example, neither the identity of the members (owners) nor the contributions they agree to make to the LLC need be disclosed. The name of an LLC must include "limited liability company," "L.L.C." or "LLC." For example, the name Indiana Physicians, LLC, would meet this requirement.

The rights and responsibilities of members are set forth in the operating agreement. In drafting an operating agreement, the parties would determine such key matters as responsibility for capi-

tal contributions, allocations of profits and losses and distributions of cash. This freedom of contract gives the LLC the same type of planning flexibility that is available in a partnership format – but without the partnership cost of personal liability.

Like a general partnership, an LLC may be managed by its members. For LLCs structured in this manner, each member is an agent of the LLC, and the action of any member binds the LLC. Alternatively, in situations where it is necessary or advisable to limit the number of members who can bind the LLC in dealings with third parties or otherwise limit the authority of members, the articles of organization may provide for the appointment of managers to manage the LLC.

Under the act, the interests of the physician-members are not freely transferable unless otherwise provided in the operating agreement. Because many medical practice groups do not want their physician-members to have the ability to sell their interests to others, this restriction on transferability should be welcome to most physician practice groups. Such a restriction may also be necessary to prevent the LLC from engaging in the "unauthorized practice of medicine" by having nonlicensed members.

Conversion to LLCs

Converting an existing partnership to an LLC should not involve any substantial adverse tax consequences. The issues involved in converting a professional corporation to an LLC are more complex. Physicians operating their practices through professional corporations should consult with their advisers to determine whether conversion to an LLC would have any significant adverse tax consequences. Depending on the specific corporate structure involved, the tax considerations may be significant.

Physicians who practice outside of Indiana also should consider whether the other states in which they practice authorize physicians to practice using the LLC form.

Conclusion

With their flexible organizational structure and liability protections, LLCs are well-suited for physicians. Members can enjoy the same type of limited liability enjoyed by corporate shareholders, while preserving the tax benefits of a partnership. The advantages and disadvantages to a physician's practice of converting to an LLC will vary and must be analyzed on a case-by-case basis. Many physicians may conclude that the LLC alternative is right for them. ❑

The authors are partners in the Indianapolis office of Baker & Daniels. Worrell is a member of the firm's business services team and helped draft the Indiana Business Flexibility Act. Tanner is a member of the firm's health care team and represents health care providers in all aspects of health care law.

How can you guarantee a successful retirement?

Joel M. Blau, CFP
AMA Investment Advisers Inc.

Poor planning is the most common reason physicians fail to enjoy a financially successful retirement. As the saying goes – people don't plan to fail; they fail to plan. Although we may feel there's never a good time to begin to plan, we must begin today.

Successful retirement planning requires three key elements: setting clear goals, maximizing tax benefits and exercising discipline.

Setting clear goals
First ask yourself such basic questions as: When do I plan to retire? Will I most likely completely retire, or will I continue to do something to generate income? What overall income objective do I have for my retirement? Answers to these and similar questions should provide you with the foundation on which to build your retirement plan.

Next, take stock of your retirement assets. What benefits can you expect from your retirement plans? Should you count on Social Security? What rate of inflation is realistic?

Finally, study investment planning strategies. Recognize that there are different types of asset classes. Examples include cash, debt, equity or real estate. Achieving a balance among these asset classes will give you the investment planning strategy to reach your goals.

Maximize tax benefits
An easy way to think of tax benefits is to realize that there are three distinct phases of an investment: 1) the deposit or purchase phase; 2) the accumulation or growth phase; and 3) the liquidation phase. The government allows, at best, a tax benefit to be available in two of the three periods. Consider these different time periods, and do as much as possible to receive the tax benefits to which you are entitled.

Exercising discipline
All the retirement and tax planning strategies in the world will provide you with no benefits if you don't actually implement your plans. It's important to understand that you not only need to gather information to make informed decisions, but you need to act on those decisions. The earlier you begin, the greater the chance you will enjoy a financially successful retirement. The key is not just to plan but to act. ❑

The author welcomes readers' questions. He can be reached at 1-800-262-3863.

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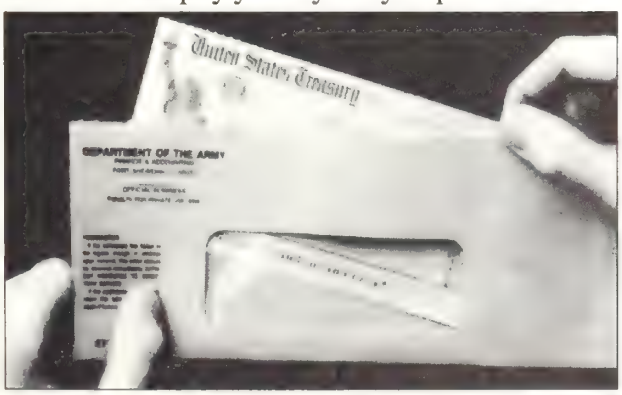
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Limited screening echocardiography in athletic exams:

Economic and administrative aspects

Erich J. Weidenbener, M.D.
Michael D. Krauss, M.D.
Bruce F. Waller, M.D.
Charles P. Taliercio, M.D.
Indianapolis

The annual preparticipation exam is a well-known ritual to most adolescent athletes. Indeed this exam is the only contact with a physician for 80% to 90% of these adolescents.[1] The exam can be performed in the physician's private office, which offers the advantages of a more intimate setting and ready access to medical records but is more expensive and time consuming. The group or station-by-station format incorporates a variety of personnel and is expedient and inexpensive while being more comprehensive. Some feel this format is the best for identifying abnormalities.[2]

The objectives of the exam include a determination of general health and evaluation of pre-existing injuries and medical conditions. The exam should also be effective in detecting previously undiagnosed conditions that may be exacerbated by athletic participation.[3] The best method of detecting cardiovascular conditions that may predispose the athlete to sudden death has been a controversial subject in recent years. Most of the discussion has centered on the use of echocardiography as a screening tool for cardiovascular disease.[4]

Certain structural heart abnormalities predispose the school-aged athlete to sudden death. Hypertrophic cardiomyopathy is the most common structural abnormality responsible for death in young athletes.[5] In addition to hypertrophic cardiomyopathy, echocardiography can identify other serious structural abnormalities that might preclude participation in athletics.

The incidence of congenital heart disease in the general population is thought to be about 0.5%.[6] Some of these abnormalities put an athlete at risk for sudden death, although certainly not all of those with an abnormality will experience sudden death. The preparticipation history and physical exam has been considered an adequate screening tool for serious abnormalities, but only in about 25% of young athletes who experience sudden death is a cardiovascular problem suspected.[5] This is not necessarily a failure of the preparticipation history and exam since some abnormalities can be asymptomatic and have a paucity of physical findings. Nevertheless, echocardiography is more sensitive in identifying serious structural abnormalities.

There is disagreement on the value and cost effectiveness of screening large asymptomatic populations for structural heart abnormalities. Arguments against using echocardiography as a screen include the high cost of the exam and the low prevalence of congenital heart disease.[6] While acknowledging that the ability of the history and physical exam to detect hypertrophic cardiomyopathy is low, Braden and Strong[7] fear the inclusion of an echocardiogram in a screening process would be too time-consuming and a "logistic nightmare."

Our hypothesis is that a screening parasternal long- and short-axis, single- view, two-dimensional echocardiogram can be an economical and effective screening tool to identify structural cardiac abnormalities that predispose to sudden death. Furthermore, we believe the echocardiogram provides additional valuable information over and above the traditional preparticipation history and physical exam in the school-aged athletic population.

Methods and patients

The preparticipation exams done by the Methodist Sports Medicine Center are comprehensive and encompass multiple aspects: history (history form), general physical exam (including cardiovascular), orthopaedic and flexibility examinations. We visit approximately 25 high schools in the Indianapolis and surrounding areas and examine more than 4,000 athletes annually, usually in May and August. We use a station-by-station format with registered nurses, athletic trainers, physical therapists, primary care physicians and orthopaedists. Athletic directors distribute our history and physical forms to the students several weeks in advance so parents can assist in filling out the

medical history and sign for consent.

Our station-to-station format uses the gymnasium, the male and female locker rooms and often adjacent hallways or classrooms. Height, weight, pulse, blood pressure and visual acuity are recorded. Certified athletic trainers and physical therapists perform a comprehensive flexibility exam, with instructions given where appropriate. The medical history is carefully reviewed with each athlete. Sports medicine internists, family practitioners, primary care residents from a large teaching hospital and occasionally senior medical students rotating at our clinic perform the exams. The orthopaedic history is reviewed, and staff sports medicine orthopaedists or sports medicine fellows perform orthopaedic exams. Any deficits noted that could preclude participation, from poor visual acuity to an ACL deficient knee, are recorded on a separate multi-copy form with recommendations for follow-up. The athlete takes one form home, and the athletic department keeps the other. With this system, proof of appropriate follow-up is documented before participation is allowed.

In addition to our usual preparticipation exam format described above, in 1992 we included an echocardiographic station. A newly conceived "screening echocardiogram" employed parasternal long- and short-axis, two-dimensional views as part of the screening process. The parasternal long- and short-axis views were chosen as the "screening" view because these images can detect four leading potentially fatal congenital heart defects – hypertrophic cardiomyopathy, Marfan's aorta, mitral valve prolapse and aortic valve stenosis.[4] Research boards of Methodist and St. Vincent hospitals approved a separate echocardiography consent form.

Several Hewlett-Packard echo machines (SONOS 500) were transported to each school and set up in the exam area. We used four to five machines per school, depending on the number of students expected to be examined. A female echo technician examined the female athletes in a private area. When possible, a female coach also was present. The male athletes were usually examined in the open gym as a separate station. All exams were recorded on VHS videotape. Each exam was coded with the athlete's age, gender, school and machine number. Individual names were not included on the tape. The code number, i.e. machine C, exam 27, was cross-referenced on the echo consent form and on the history and physical form to facilitate easy follow-up on abnormalities. Each echo exam took approximately two minutes, with many examinations performed within one minute. If an abnormality was noted by the technician, additional views and/or Doppler echocardiography was employed,

Table 1

Cost of echocardiographic screening study

Technician salaries*	$21,600
Supplies (VHS tape, gel, etc.)	$400
TOTAL	**$22,000**

Cost per 2-D Echo screen per athlete: $7.34

* Technician salaries reflect 1 1/2 time base pay as evening overtime pay.

Note: The above costs reflect no charge for echocardiography interpretation, echocardiographic machine rental or machine transportation costs. All of these costs were donated by physicians, Hewlett-Packard Co. and the St. Vincent Foundation. We believe these services would be provided in most instances as a public service to the high schools.

requiring an additional two to four minutes. A cardiologist (BFW) was present for most of the exam sessions.

An echocardiographer (CPT) reviewed all echocardiograms. Readings were usually done within one week of examination, with abnormal results reported back to the other authors (EJW and MDK). Parents of the athletes with abnormal screening echocardiograms were notified by telephone and informed of the abnormality and advised of its significance regarding athletic participation. Any necessary follow-up was referred initially to the student's family physician. If an athlete did not have a physician, we made an appropriate referral.

Discussion

To our knowledge, no large-scale echocardiographic screening of school-aged athletes has ever been reported and possibly never attempted. A total of 2,997 was done during this study. The logistics were carefully planned and potential problems addressed well in advance. The process went smoothly, with no major obstacles encountered. The Methodist Sports Medicine Center staff has spent 10 years refining the station-by-station format, which facilitated the addition of an echocardiogram station without additional time delays. The echocardiographic screening was well-received by coaches, parents and the athletes.

The Indiana Heart Institute and the St. Vincent Hospital Foundation covered all costs of the exams. There was no cost to the school or the athletes. St. Vincent Hospital, Nasser Cardiology Inc. and Hewlett-Packard provided Hewlett-Packard echocardiographic machines. Transportation was provided by a hospital vehicle. Certified echocardiography technicians who were paid time and a half for evening sessions performed the exams.

Initially, we included a rhythm strip as part of the echocardiographic exam. However, placement of the electrodes was time consuming and more than doubled the time spent at the echo station, which slightly lengthened the overall process. We therefore omitted this from all subsequent schools and noted arrhythmias from the echocardiogram alone. A rhythm strip could provide valuable information, especially with the recently reported incidence of long QT syndrome associated with the non-sedating antihistamines.[8]

The most common reason for non-participation in the study was the lack of a signed consent form. Some simply forgot the form, while others never received it. A high percentage of the athletes evaluated in the spring had echoes done (1,870 echocardiograms out of 2,282 exams or 82%). During the summer, however, only 62% received echoes because the forms were not given to the students in a timely manner, presumably because school was not in session, despite the fact that athletic directors had the forms well in advance. Parents or athletes rarely declined the echocardiogram because of disinterest.

We notified the parents if we discovered abnormalities, but it was not uncommon for the athlete's physician to later request information about the echo findings. The study itself and the individual findings were fully discussed while emphasizing this was a single-view screening echocardiogram. Further evalua-

Table 2

Potential additional costs

Echocardiogram interpretation*	$5,129
Echo machine rental+	$13,200
Transportation#	$1,050
TOTAL	**$19,379**

Additional cost per athlete: $6.34

Total per athlete: $13.81

* $60/hour reading 35 screening Echos/hour
\+ Machine rental $150/machine/session
\# Transportation to sites $50/session

Note: We emphasize that these latter costs would be unlikely in performing the echocardiography screening.

tion was left to the discretion of the private physician.

The overall cost was calculated and based on supplies and the cost of paying overtime to echocardiogram technicians. For this study, the cost per echocardiogram was $7.34 per athlete *(Table 1)*. Additional costs could include rental of echo machines, transportation and echocardiogram interpretation if these had not been provided. Incurring these costs would still limit the cost to less than $14 per athlete *(Table 2)*. Considering that the echo would only need to be done once during high school, this cost hardly seems prohibitive, even for those of limited means. The athlete is charged $10 for the preparticipation exam, with $5 going to the school and $5 to offset overtime for our trainers and therapists. Adding the cost of the potential echocardiogram to the fee above still keeps the cost for that particular year under what would be charged for a physical exam in a private office.

A large group with an interest in sports medicine can perform this type of screening with few difficulties. In a smaller community, this task would be more difficult and require the coordinated effort of several groups, such as physicians, hospitals and school systems.

We currently are evaluating the echocardiographic results and correlating them with the historical findings (relating to the cardiovascular system) and physical findings. This will provide valuable information as to the accuracy of the traditional history and physical from a preparticipation exam in identifying cardiac abnormalities.

With proper organization and personnel, echocardiography can be used in a preparticipation exam setting efficiently and economically. ❑

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References

1. Risser WL, et al: A cost benefit analysis of preparticipation examinations of adolescent athletes. *J School Health*, 55(7):270, 1985.

2. Durant RH, et al: The preparticipation examination of athletes. *Am J Dis Child*, 139:657, 1985.

3. Hara JH, Puffer JC: The preparticipation physical examination. In: *The Team Physician's Handbook*, Philadelphia, Pa: Hanley & Belfus: 1990:18-25.

4. Waller BF, Harvey WP: *Cardiovascular Evaluation of Athletes. Toward Recognizing Young Athletes at Risk of Sudden Death.* Newton, NJ: Laennec Publishing; 1993:1-213.

5. Maron BJ, et al: Sudden death in young athletes. *Circulation*, 62:218-229, 1980.

6. Epstein SE, Maron BJ: Sudden death and the competitive athlete: Perspectives on preparticipation screening studies. *J Amer Coll Cardiol*, 7:220-230, 1986.

7. Braden DS, Strong WB: Preparticipation screening for sudden cardiac death in high school and college athletes. *The Physician & Sports Medicine*, 16 (10):128-140, 1988.

8. Simons FER, et al: Astemizole-induced torsade-de-pointes. *Lancet*, 2:624, 1988.

Military miniatures rank high in doctor's life

Tina Sims
Managing Editor

Don't tell Murff Box, M.D., not to sweat the small stuff. It's all small stuff to Dr. Box, a painter of military miniatures.

The Huntingburg internist has been spending his spare time with military miniatures for the past 13 years. He first became interested in the hobby while serving as a medical officer on a U.S. Navy submarine off the coast of Scotland. During shore visits to Glasgow and Edinburgh, he noticed the popularity of military miniature painting on the British Isles. He's been hooked ever since.

Many of Dr. Box's miniatures portray characters from the nation of kilts and bagpipes where he was first introduced to the hobby. They include an Argyle and Sutherland Highlander from the Boer War, a Scottish Highland Chief from the Jacobite Rebellion of 1720, Black Watch Highlanders from the Boer War and the Crimean War and a Black Watch bagpipe player from 1984. A Cameron Highlander from the Egyptian campaign of the late 1800s won a pewter medal in competition at the annual Military Miniature Society of Illinois show in Chicago.

Several Russian figures also occupy space in the collection. They include a Muscovite Renji, a palace guard for the Russian czar dressed all in white, and a recently-completed Muscovite Boyar, a landowner from the 1600s called to fight for the czar.

Most of the figures in Dr. Box's collection are commercial castings, but some hand-sculpted miniatures are also included. The bust of his grandfather, a member of an artillery coastal battalion in Florida during World War I, is the hand-sculpted piece of which he is proudest. Dr. Box created the figure from a photograph since he never knew his grandfather, somewhat of a "rogue" whose troubles with the law kept him on the run, Dr. Box explains. If the bust of his grandfather wins a prize at an upcoming competition, Dr. Box plans to sculpt busts of several World War I generals as his next project and enter them in theme award competition.

A steady hand is required for painting the diminutive figurines. "I never drink too much coffee and I don't drink alcohol" when painting, says Dr. Box. The smallest figures are 54 mm, or 2.16 inches, and the tallest miniature figures are 200 mm, or 8 inches.

Although many people assume that the larger figures would be easier to paint, Dr. Box says the opposite is true. "The big figures are more difficult because there's more detail on them," he says. He estimates he spends about 50 hours painting a 120-mm figure and 15 hours on a 54 mm figure. That time doesn't include the preparation work, which can involve tasks such as gluing the parts together and filling in any gaps. Preparation time can add another five hours or more to the project.

"Painting the faces is the hardest," says Dr. Box. Part of the challenge lies in achieving a skin tone that accurately represents the nationality of the character. Because some Russian soldiers had Tartar roots, for example, Dr. Box strives for a flesh color with a hint of yellow.

"We strive for accuracy," he says. Although many miniature kits come with painting instructions, experienced hobbyists such as Dr. Box often go the extra step that sets them apart in competition. He may tinge a coat with a shade of brown so that it looks soiled or create the effect of worn spots on knees or elbows by subtle mixing of colors. Dr. Box stripped the paint off his Cameron Highlander figure three times before he was satisfied with the finished product, which earned a medal in competition in Chicago.

To give him a further edge in competition, Dr. Box paints only under incandescent light because judging at shows takes place under that type of lighting.

Because he also is avidly interested in military history, Dr. Box appreciates the details of the figures that might go unnoticed by others. His Kaiser Wilhelm II miniature has a left arm that is shorter than the right, accurately depicting the result of an injury at birth.

Fashioning authentic groundwork for the wooden base on which the figures stand also helps in competition. Snowy terrain, created from a dusting of baking powder, is fitting for the Russian Cossack, while a more verdant look, achieved with static grass, is appropriate for the "goat major" of the Royal Welch Fusilers.

"I spend most of my spare



Dr. Murff Box applies the finishing touches to the newest miniature in his collection.



These miniatures are representative of the figures in Dr. Box's collection.

time doing this," he says of his hobby. Sometimes he gets so involved in a project that he can work until 12:30 or 1 a.m., listening to country music all the while.

He enjoys knowing that his work will result in a finished piece that will reflect his precision and talent. But there's another reason he finds the hobby so appealing: "My figures listen to me and my patients often don't."

He does admit to occasionally burning out after completing a particularly detailed piece. "It sometimes gets frustrating. It becomes a disease after a while," he says.

Still, he tries to maintain a balanced attitude about his pastime and the competition. After once coming home from a show without a medal and feeling very disappointed, he now reminds himself that "winning isn't the only thing."

"A lot of guys take this seriously. If they don't win, they're upset. Obviously I want to win, but if I don't, I've still had a good time. It's nice to win, but you have to remember it is just a hobby."

He has served as a judge, but that doesn't hold much appeal. "My biggest aspiration is to win a gold medal in Chicago. Heck, I'd even settle for a silver or bronze in Chicago," he says.

To improve his chances of winning, he takes at least three or four miniatures to every show. "If you just take one, you're putting all your eggs right there," he says, whereas participants with more entries are more likely to attract the attention of judges, who assume there's probably something in the group worth mentioning.

He enjoys the friendships of his fellow miniaturists at the shows. "I'd sooner skip Christmas than miss a show."

Dr. Box is a member of the Historical Miniature Society of Northeast Oklahoma and the Military Miniature Society of Illinois and annually attends their shows. He's also "saving his shekels" to attend the 1994 Euro Militaire show, held every September in Folkstone, England.

He intends to continue painting miniatures far into the future. A closetful of unpainted figures – termed the "great gray army" by Dr. Box – still awaits his attention. ❑

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Surgical management of ventricular tachycardia

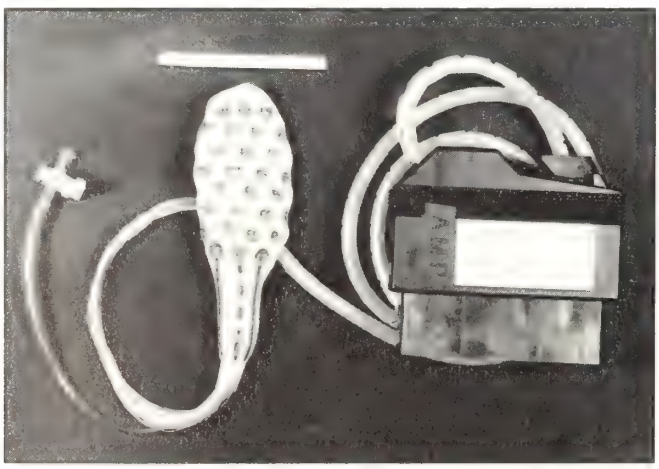
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Abstract

Advances in portable high-speed computer technology have allowed intraoperative mapping of the ventricular endocardium. Accurate and highly precise endocardial maps have rendered certain types of ventricular tachycardia curable. This article discusses the options available to patients with ventricular tachycardia and places special emphasis on high-speed precision mapping and endocardial resection for cure.

Death due to ventricular arrhythmia remains a principal cause of cardiac mortality, resulting in a major allocation of health care resources to the solution of this problem.[1,2] The alternative approaches to therapy include pharmacologic therapy, implantable cardioverter defibrillator (ICD), cardiac transplantation and ventricular tachycardia surgery. In this review, each alternative will be discussed, with particular emphasis upon the surgical approach to treating ventricular tachycardia (VT).

Pharmacologic therapy, the most often applied therapeutic modality, remains effective in suppressing sustained ventricular tachycardia.[3] Many patients cannot tolerate the numerous side effects. Proarrhythmia and cardiac depression can occur, particularly in patients with poor ventricular function.[4] In addition, concern has recently developed over increased mortality with pharmacologic therapy in certain subsets of patients with ventricular arrhythmia.[1] The toxicity of amiodarone, the least depressive of the antiarrhythmia drugs, is cumulative.[3,4] Pharmacologic therapy is increasingly being "guided" by electrophysiologic (EP) laboratory procedures.[5] Pharmacologic treatment with or without EP guidance remains the principal treatment of ventricular arrhythmia.[3-5]



Endocardial balloon electrode array used to map the ventricular chamber.

Implantable cardioverter defibrillators (ICD) that provide antitachycardia pacing and shock therapy are now available for unrestricted use. These devices are expensive and require considerable follow-up surveillance.[9,10] Recent concern has developed over the potential for overuse.[7] Nevertheless, ICDs have contributed significantly to the reduction in overall mortality due to cardiac arrhythmia.[6,10] Patients most likely to benefit from ICD therapy include: 1) patients who survive sudden cardiac arrest due to cardiac arrhythmia not associated with acute ischemia; 2) patients

Table 1

Indications for ventricular tachycardia surgery

- Patients with a ventricular aneurysm
- Patients with antero-apical scar tissue
- Mono or dimorphic VT
- EF > 30%
- Absence of severe hepatic, pulmonary or renal dysfunction

with sustained ventricular tachycardia not suppressible with pharmacologic therapy; and 3) patients unable to tolerate sufficient pharmacologic therapy to prevent arrhythmia breakthrough.[6,10] A potential use under investigation employs ICD therapy as a bridge to transplantation in arrhythmia-prone patients with severe left ventricular dysfunction.[8] Extensive government oversight in the use of these devices is to be expected.[7]

Cardiac replacement or transplantation is the definitive therapy for life-threatening arrhythmias. Poor ventricular function and clinical evidence of power failure make this modality particularly useful. Rejection, infection and an insufficient number of cardiac donors remain problematic. Cardiac mortality occurs in 15% of patients awaiting cardiac transplantation.[11] Considerable effort has been made to expand the number of cardiac donors, to little avail.[12] Cardiac replacement, therefore, will remain a limited approach to the treatment of cardiac arrhythmia.

Surgical ablation of ventricular tachycardia in properly selected patients is highly successful.[14-18] Advantages include: 1) the procedure can be curative; 2) correction of concurrent cardiac problems, e.g. ventricular aneurysm, coronary artery disease; 3) no permanent foreign body implantation; 4) no intensive medical surveillance required postoperatively; and 5) simplified pharmacologic therapy.

The pathophysiologic principle that allows a surgical attack on ventricular tachycardia involves localized abnormal conduction.[18] Heterogeneous conduction allows differential propagation of electrical impulses, giving rise to reentry. This process can be identified intraoperatively by multipoint mapping, with portable computer systems capable of mapping simultaneously (multiplexing) large areas of the ventricular endocardium. Interruption of any point along a reentry circuit terminates the arrhythmia.[18]

Abnormal conduction is identified by placing a multi-channel electrode array attached to an inflatable balloon into the ventricular chamber *(Figure)*. This is performed using cardiopulmonary bypass. The balloon is inflated until coaptation of the electrodes with the ventricular endocardium occurs. Ventricular tachycardia is induced by programmed electrical stimulation. Analysis of the simultaneously received signals demonstrates precisely the location of abnormal conduction. This area is then excised if possible. If the location is inaccessible to resection, then cryoablation or argon beam coagulation is performed to homogeneously destroy the abnormal myocardium.[19] Other cardiac abnormalities are then corrected, and the operation is concluded.

Patients most suitable for map directed VT surgery are listed in *Table 1*.[16,17] Contraindications include those listed in *Table 2*.[20,21]

Before map-directed endocardial resection, surgery for arrhythmia control produced inadequate results. In patients with anterior reentry and monomorphic VT, a cure rate of 95% can now be achieved with map-directed endocardial surgery. Mortality rates of 5% or less also are achievable.[21] Posterior located reentry, due to involvement of the mitral apparatus and aortic outflow tract, is somewhat more difficult to ablate.[16,20] Success rates of 60% to 80% have been achieved in this location.

Summary

A variety of therapeutic advances in pharmacology, ICDs, transplan-

Table 2

Contraindications for ventricular tachycardia surgery

- Non-reproducible VT
- Polymorphous VT
- Severe ventricular dysfunction EF < 20%
- Hemodynamic compromise

tation, and computer-directed arrhythmia surgery has occurred. These improvements have conspired to produce significant enhancement in the lifespan of patients prone to serious ventricular arrhythmia. ❑

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drug names

Look-alike and sound-alike drug names

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Brand name:	Cinobac, Dista	Ciloxan, Alcon
Generic name:	Cinoxacin	Ciprofloxacin
Dosage forms:	Capsules	Ophthalmic solution
	ASENDIN	**ANSAID**
Category:	Antidepressant	Nonsteroidal anti-inflammatory agent
Brand name:	Asendin, Lederle	Ansaid, Upjohn
Generic name:	Amoxapine	Flurbiprofen
Dosage forms:	Tablets	Tablets

Look-alike and sound-alike drug names can be misinterpreted by a nurse reading doctors' orders or by a pharmacist compounding physicians' prescriptions.

Such misunderstandings can result in the administration of a drug not intended by the prescriber. Awareness of such look-alike and sound-alike drug names can reduce potential errors. ❑

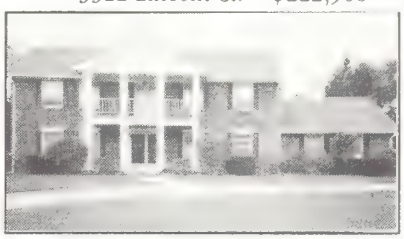
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Maternal mortality in Indiana: A report of maternal deaths in 1991

William D. Ragan, M.D.
Indianapolis

This is the annual report of the Indiana Maternal Mortality Study Committee. In 1991, Indiana reported 13 pregnancy-related deaths and 85,661 live births. This gives the state a pregnancy-related death ratio of 15.17 per 100,000 live births for 1991. Correcting for one non-obstetric death (Case 115), the maternal mortality ratio for 1991 was 14 per 100,000.

The committee met at 11:30 a.m. June 3, 1992, at the Indiana University Medical Center Student Union Building for a closed discussion of the 13 deaths. Each case was presented for discussion, establishment of diagnosis and assignment regarding preventability and responsibility.

Case 805 – Jan. 17, 1991. A 32-year-old married white woman, G7, P2, Ab4, 10 weeks gestation. Death was considered obstetric and indirect. Cause of death was infection (*Streptococcus pyogenes sepsis*).

Case 806 – March 21, 1991. A 35-year-old married white woman, G2, P2, term pregnancy. Death was considered obstetric and direct. Cause of death was anesthesia (total spinal).

Case 807 – June 4, 1991. A 20-year-old married white woman, G1, P0, 30.5 weeks gestation. Death was considered obstetric and direct. Cause of death was infection. Varicella with superimposed pneumonia. Diabetes mellitus, severe.

Case 808 – June 22, 1991. A 32-year-old single white woman, G1, P0, 11 days post partum, 32 weeks gestation. Death was considered obstetric and indirect. Cause of death was medical complication in pregnancy. Marfan's syndrome, myocardial infarction and aortic dissection.

Case 809 – Aug. 15, 1991. A 17-year-old single black woman, G1, P0, five weeks post partum. The baby was delivered by cesarean section at 31 to 32 weeks gestation. Cause of death was toxemia of pregnancy. Eclampsia and intracerebral hemorrhage.

Case 810 – Sept. 19, 1991. A 28-year-old single black woman, G5, P5, six days post partum. She had delivered a term-sized infant. Death was considered obstetric and indirect. Cause of death was medical complication in pregnancy. Cerebral vasculitis and subarachnoid hemorrhage.

Case 811 – Oct. 7, 1991. A 24-year-old married white woman, G2, P2, six months post partum. She had delivered a full-term infant. Death was considered obstetric and direct. Cause of death was medical complication in pregnancy. Postpartum cardiomyopathy.

Case 812 – Oct. 9, 1991. A 23-year-old married white woman, G3, P2, AB1, seven days post partum. She had had a term delivery. Death was considered obstetric and indirect. Cause of death was medical complication in pregnancy. Possible cardiomyopathy. Adult respiratory distress syndrome.

Case 813 –Nov. 3, 1991. An 18-year-old single white woman, G1, P0, eight weeks post partum. Uncomplicated term vaginal delivery. Cause of death was considered obstetric and direct. Cause of death was medical complication in pregnancy. Postpartum cardiomyopathy.

Case 814 – Nov. 26, 1991. A 17-year-old single white woman G1, P0, 24 weeks gestation. Death was considered obstetric and indirect. Cause of death was infection. Disseminated herpes Type II.

Case 815 – March 7, 1991. A 23-year-old married white woman, 24 weeks gestation. Death was considered nonobstetric. Cause of death was homicide.

Case 816 – March 22, 1991. A 27-year-old married white woman, G3, P2, 40 weeks gestation. Death was considered obstetric and direct. Cause of death was amniotic fluid embolism.

Case 817 – June 27, 1991. A 20-year-old single black woman,

G5, P1, Ab2 ectopic 1, 15 weeks gestation. Death was considered obstetric and direct. Cause of death was hemorrhage, ruptured left cornual pregnancy.

Discussion

There is a changing trend as to the cause of maternal death. Time-honored causes have been hemorrhage, infection and toxemia. In the United States, emerging causes of maternal deaths are now embolism, cardiomyopathy, anesthesia complications, adult respiratory distress syndrome and acquired immunodeficiency syndrome.[1-4]

The leading cause of maternal death in the United States is pulmonary embolism. Thromboembolism remains an enigma, because early recognition and prevention are difficult. Pregnant women are at risk because of the hypercoagulable state associated with pregnancy. Clinical awareness of the signs and symptoms of deep vein thrombosis and prompt initiation of diagnostic and therapeutic measures are the cornerstones of avoiding a life-threatening pulmonary embolus.[9,10]

There are 10 cases of air embolism in the Indiana maternal mortality files. These often are related to oral/genital activity, and education of antepartum patients would be helpful.[11] Amniotic fluid embolism is rare, although one of the 1991 deaths was caused by this entity.

Adult respiratory distress syndrome (ARDS) in pregnancy is associated with a maternal mortality of 44%. The main causes of ARDS in pregnancy are hemorrhage, infection and toxemia.[5] Because it is projected that AIDS will increase among women, more cases of pregnancy-associated deaths due to this cause will occur.[12] There has been concern that the rising cesarean section rates in the United States might result in an increase in maternal mortality, but at least one article has shown that the risk of maternal death from cesarean section is low.[13]

In a recent report, trauma was listed as a leading cause of nonobstetric maternal death. Mechanisms of injury in traumatic maternal death include gunshot wounds, motor vehicle crashes, stab wounds, strangulation, blunt head injuries, burns, falls, toxic exposure, drowning and iatrogenic injury.[6]

In Indiana, the leading causes of maternal death are now medical complication and pregnancy, hemorrhage, embolism, infection, toxemia and anesthesia.[7,8] Physician education, increased availability of prenatal care and proper referral may help the pregnant patient avoid a medical complication. Until 1991 (case 817), maternal death due to ruptured ectopic pregnancy had not occurred in Indiana since 1984. Early diagnosis of this condition is now possible with sensitive pregnancy tests, ultrasound and laparoscopy. Deaths due to toxemia often represent a lack of prenatal care and can be prevented.

The American College of Obstetricians and Gynecologists and the Centers for Disease Control (CDC) in Atlanta continue to collect data on maternal deaths by states and districts.[1] The CDC has initiated a pregnancy mortality surveillance study. The U.S. Department of Health and Human Services has set a goal of no more than 3.3 maternal deaths per 100,000 live births by 2000.[14] In the United States in 1985, the maternal mortality ratio for all races was 7.8 per 100,000 live births. For white women, the ratio was 5.2; for all other races, it was 18.1. For black women, the ratio was 20.4 per 100,000 live births.

The high maternal mortality rate for nonwhite women is a problem that must be overcome.[15] Combined efforts by these organizations should provide more meaningful statistics to help curtail preventable maternal mortality in the United States. Several recent articles have stated that maternal mortality is one of the great neglected problems of health care in developing countries. Rates are as much as 100 times higher than those in industrialized countries.[16,17]

Pregnancy-related deaths continue to be underreported. Often, no mention is made on the death certificate that a pregnancy was involved. In an effort to pick up missed cases, at least one state has instituted a method in which live birth records are matched with death records for women of reproductive age to detect if a woman died within one year of delivery.[18] A year ago a "check box" relating to pregnancy was placed on the Indiana death certificate to help identify missed cases.

Maternal mortality still occurs. While the numbers are small, the members of the Indiana State Maternal Mortality Study Committee believe that it is important to investigate and report these deaths for statistical and educational purposes. According to our records, many of these deaths are preventable or have preventable factors. In addition, there are undoubtedly many near misses. We must remain vigilant. ❑

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References

1. Rochat RW, et al: Maternal mortality in the United States: Report from the Maternal Mortality Collaborative. *Obstet Gynecol*, 72(1):91-97, 1988.

2. Sachs, BP, Brown DAJ, Driscoll SG, et al: Maternal mortality in Massachusetts trend and prevention. *N Engl J Med*, 316(11):667-672, 1987.

3. Atrash HK, et al: Maternal mortality in the United States, 1979-1986. *Obstet Gynecol*, 76(6):1055-1060, 1990.

4. Atrash HK, et al: Maternal and perinatal mortality. *Current Opinion in Obstet Gynecol*, 4:61-71, 1992.

5. Mabie WC, Barton JR, et al: Adult respiratory distress syndrome in pregnancy. *Am J Obstet Gynecol*, 167(4):950-957, Part 1, 1992.

6. Fields J, Ree L, et al: Trauma: The leading cause of maternal death. *J Trauma*, 32(5):643-645, 1992.

7. Ragan WD: Maternal mortality in Indiana: A report of maternal deaths in 1988. *Indiana Med*, 83(10):730-731, 1990.

8. Ragan WD: Maternal mortality in Indiana: A report of maternal deaths in 1989. *Indiana Med*, 84(10)704-705, 1991.

9. Franks AL, Atrash HK, et al: Obstetrical pulmonary embolism mortality: United States 1970-1985. *Am J Public Health*, 80:720, 1990.

10. Rutherford SE, Phelan JP: Deep venous thrombosis and pulmonary embolus. In: *Critical Care Obstetrics*. 2nd ed. Boston, Mass: Blackwell Scientific Publications; 1991:150-179.

11. Ragan WD: Antepartum air embolism. *J Ind State Med Assoc*, 74(1): 30-32, 1981.

12. Koonin LM, Ellerbrocker TV, et al: Pregnancy-associated deaths due to AIDS in the United States. *JAMA*, 71(3):1306-1327, 1988.

13. Sachs BP, et al: Cesarean section-related maternal mortality in Massachusetts, 1954-1985. *Obstet Gynecol*, 71(3):385-388, 1988.

14. U.S. Department of Health and Human Services: *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, conference ed. Hyattsville, Md: Public Health Service, 1991.

15. Ellerbrock T, Atrash H, Hogue C, Smith J: Pregnancy mortality surveillance: A new initiative. *Contemporary Ob/Gyn*, 31:23-24, 1988.

16. Rosenfield, A: Maternal mortality in developing countries. *JAMA*, 262(3):376-379, 1989.

17. Languardia DD, et al: A 10-year review of maternal mortality in a municipal hospital in Rio de Janeiro: A cause for concern. *Obstet Gynecol*, 75(1):27-32, 1990.

18. Dye TD, Gordon H, et al: Retrospective maternal mortality case ascertainment in West Virginia, 1985-1989. *Am J Obstet Gynecol*, 167(1):72-76, 1992.



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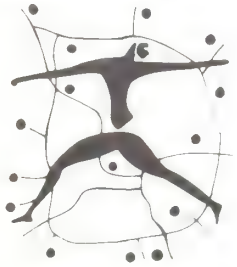
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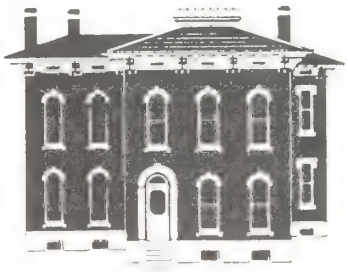
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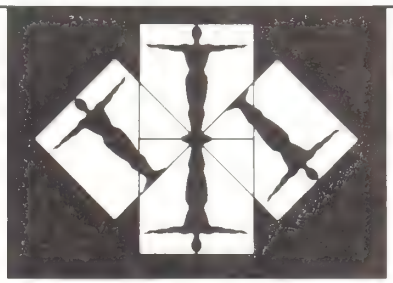
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alliance report

Sue Ellen Greenlee, ISMA Alliance president
Lucy Reed Foltyniak, corresponding secretary

Put Jan. 12 on your calendar! The ISMA and ISMA Alliance will join forces for Medicine Day in Indianapolis. This special day will include activities previously emphasized at Day at the Capitol. Join us at the Westin Hotel for a breakfast briefing by the ISMA Government Relations staff, a visit to the Statehouse to meet legislators and observe sessions and share lunch with legislators at the Westin Hotel. The Alliance board meeting will be held in the afternoon, followed by the ISMA/IMPAC Legislative Reception.

With the U.S. health care system under serious scrutiny and proposed changes to this system being considered, we must stay focused and involved, educating ourselves, other physicians, county Alliance members and the general public concerning these proposed changes. We must become part of the process or be content with the outcome. Let us have a voice!

Two resolutions introduced at the 1993 ISMA convention by the ISMA Board of Trustees and the ISMA Alliance involve family violence. The resolutions seek the inclusion of two declarations: one to amend the state birth certificate and the second to amend the state marriage license application. These declarations affirm the right of each child, spouse or other family member to live free from violence and abuse and that physical abuse, sexual abuse, battery and assault of a child, spouse or other family member are violations punishable by state law. The ISMA House of Delegates voted to refer the resolutions to the Board of Trustees with the recommendation that the resolutions be referred to the Ad Hoc Committee on Domestic Violence for implementation. ❑

Confluence

Confluence is the leadership conference sponsored annually by the AMA Alliance to educate county leaders. Attendees learn how to plan and organize their presidential year and how to be strong leaders in the Alliance and in their communities. They also receive information on current health programs that will receive major focus.

County presidents-elect who attended Confluence I

Elkhart County	Judy VanCuren
Grant County	Raji Rehil
Indianapolis	Marcia Rice
Monroe-Owen	Carolyn Lindsay
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Wayne/Union	Vickie Flint

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Annual Meeting: May 11, 1994
7 - Pres: Paula Hall, Mooresville
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Annual Meeting: to be announced
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9 - Pres: Irene Gordon, Lafayette
Secy: Stephen D. Tharp, Frankfort
Annual Meeting: June 8, 1994
10 - Pres: John L. Swarner, Valparaiso
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Annual Meeting: April 30, 1994
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12 - Pres: Joseph Mantheiy, Bluffton
Secy: Brenda Stiles, Fort Wayne
Annual Meeting: Sept. 15, 1994
13 - Pres: Alan H. Bierlein, Bristol
Secy: John W. Schurz, South Bend
Annual Meeting: March 23, 1994

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from the museum

Oren Cooley
Indianapolis

The current exhibit at the Indiana Medical History Museum in Indianapolis enables visitors to learn about the life of artist John Zwara, the art of the insane and the impact of schizophrenia.

The exhibit, titled "The Worlds of John Zwara," explores his life through an examination not only of schizophrenia but of the art of the insane. A prolific artist who lived in Indianapolis during the 1930s and 1940s, Zwara worked primarily in watercolors to create landscapes and, occasionally, in oils.

Zwara was diagnosed with schizophrenia in 1938, upon his admission to Central State Hospital. "He was brought to the hospital by friends who thought that treatment in a mental institution might improve his peculiar social behavior," noted Walter L. Bruetsch, M.D., (1896-1977), the hospital's pathologist, in an article published in *The Journal of Nervous and Mental Disease* in 1942.

According to records, Zwara was born in Austria in the early 1880s and came to the United States around 1900. Zwara painted various scenes in Indianapolis by the early 1930s and, except for some time he spent in Brown County, Zwara remained in Indianapolis until his death.

Sleeping in the streets and often surviving on bread and coffee, Zwara earned money for his art supplies and meager diet by selling his paintings to the H. L. Leiber Co. and Lyman Brothers Inc. in Indianapolis

"He made pencil sketches in his workbooks and put numbers in areas for colors he wanted," said Carl Lyman, then president of Lyman Brothers, in an article published in 1976 by *The Indianapolis Star*. Lyman's father, Benjamin, had taken an interest in Zwara and made the company's studio available to the artist.



Artist John Zwara painted the Pathology Department and several other buildings at Central State Hospital after his admission in 1938. Today, this building houses the Indiana Medical History Museum, a private, non-profit organization established in 1969 to preserve this historic structure.

"I don't know how many numbers he had in his head but he knew exactly what colors to use when he came to the studio," continued Lyman. "It was an original paint-by-number system that he developed himself."

Indianapolis businessman Alexander Vonnegut (1888-1975) became interested in Zwara after seeing his work displayed in the windows at the H. L. Leiber Co. After meeting Zwara in 1934, Vonnegut realized that Zwara needed psychiatric help and made arrangements to have Zwara admitted to Central State Hospital.

"I earnestly hope that he [Zwara] will be given every opportunity to indulge his earnest desire to paint," wrote Vonnegut in the letter that requested Zwara's admission. When Central State Hospital accepted Zwara, Vonnegut noted, "He likes to paint out of doors but will paint morning, noon and afternoon if given a room with good light."

Zwara masterfully painted scenes of Central State Hospital's buildings and grounds before he decided to leave. Zwara remained at the hospital six months.

"The Worlds of Zwara" will be displayed until April 1994. For more information, call the museum at (317) 635-7329. ❑

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Richard R. Krug MD ISMA Ex Director

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cme calendar

St. Vincent Hospital

St. Vincent Hospital and Health Care Center in Indianapolis will sponsor these courses:

Nov. 14-15 – Fifth Annual Innovations in Vascular Care, Ritz Charles, Carmel.

Nov. 23 – Indiana Dermatopathology Conference – Local, St. Vincent Hospital.

For more information, call Beth Hartauer, (317) 338-3460.

Methodist Hospital

Methodist Hospital of Indiana in Indianapolis will sponsor these CME courses:

Nov. 19 – Fourth Annual Management of Diabetes in the 1990s, Radisson Hotel, Indianapolis.

Nov. 19-20 – Indiana Healthcare Ethics Network Symposium, Petticrew Auditorium, Methodist Hospital.

Dec. 3-4 – ATLS, Methodist Hospital.

Jan. 29 – Clinical Echocardiography, site to be announced.

Mar. 5 – Cardiology Update, University Place Conference Center, Indianapolis.

For details, call (317) 929-3733 or 1-800-847-3370.

Indiana University

The Indiana University School of Medicine will sponsor these courses:

Nov. 16-18 – Biostatistics for Physicians, Hurty Hall, Indiana University-Purdue University-Indianapolis.

Dec. 4 – Update in Cardiology for the Internist, Krannert Institute of Cardiology, IUPUI campus.

For more information, call (317) 274-8353.

University of Michigan

The University of Michigan Medical School will sponsor these CME courses:

Nov. 19-20 – Advances in Psychiatry V 1993, The Towsley Center, Ann Arbor, Mich.

Dec. 3-4 – Second Annual Women's Health Care for the Primary Care Provider, The Towsley Center, Ann Arbor, Mich.

Feb. 27-Mar. 3 – Practical Aspects of Radiology and Imaging, Marriott's Camelback Inn, Scottsdale, Ariz.

For more information, call (313) 763-1400.

Mayfield Neurological

The Mayfield Neurological Institute, associated with the University of Cincinnati Department of Neurosurgery, will sponsor these CME courses:

Dec. 2-3 – Applications of Laser Endoscopy to the Cranial and Spinal Axis, Cincinnati.

Dec. 2-3 – Neuro Nursing's Newest Challenge: Endoscopy of the Nervous System, Cincinnati.

Dec. 4 – Four State Neuroscience Conference, Cincinnati.

For more information, call Sheila Stuckey, (513) 569-5251.

University of Wisconsin

The University of Wisconsin-Madison School of Medicine will present "Orthopaedics in Primary Care" Feb. 18 and 19 at the Holiday Inn-West in Madison, Wis.

The conference will provide an overview of common orthopaedic problems, and diagnosis and management considerations will be reviewed.

For more information, call Sarah Aslakson, (608) 263-2856.

George Washington University

The George Washington University Medical Center will sponsor these CME courses:

Feb. 1-5 – 19th Annual Meeting of the Alliance for CME, Hotel del Coronado, San Diego, Calif.

Feb. 26-Mar. 5 – Topics in Gastroenterology and Internal Medicine, Marriott's Sam Lord's Castle, Barbados.

For more information, call (202) 994-4285. ❑

ISMA sponsors sports nutrition packet

The ISMA's Commission on Sports Medicine recently co-sponsored the development of a sports nutrition packet.

The packet is designed to provide basic nutrition guidelines for student athletes in grades 7 to 12. Materials are suitable for use by athletes, coaches, trainers, physicians, parents and other related support staff. Topics include daily calorie needs, recommended daily food group servings and suggested menus on practice and competition days. Special emphasis is placed on fluid requirements.

Other sponsors of the project were the Indiana State Department of Health and The Nutrition Coach.

Physicians who wish to receive a packet may call Cathie Pfarr, The Nutrition Coach, (317) 738-6204.

Huntington's disease testing offered at IU

The Indiana University Medical Center's Department of Medical and Molecular Genetics offers presymptomatic or neurological testing for Huntington's disease.

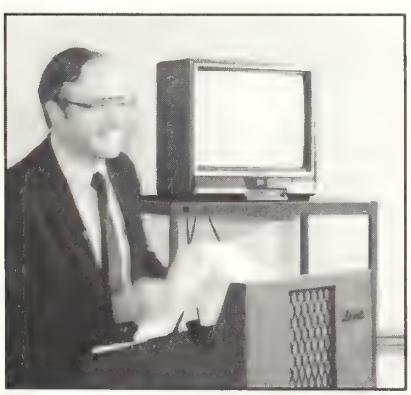
There is no effective treatment or cure for Huntington's disease, but recent discovery of the gene that causes the disease creates the opportunity for such research to be done. The disease affects at least 25,000 Americans, and an additional 125,000 are at risk of inheriting it from an affected parent.

For information on the IU testing program, call (317) 274-2241. Patients' families may call the Indiana Chapter of the Huntington's Disease Society of America, (317) 271-0624, for more information on the disease and support group meetings.

Tipton, Methodist hospitals team up to cut costs

Tipton County Memorial Hospital and Methodist Hospital in Indianapolis have formed a cooperative network designed to control costs, streamline patient service and help small hospitals stay strong enough to continue serving their communities.

The affiliation is neither a merger nor a buy-out but a partnership that allows the hospitals to share medical expertise, continuing education for physicians and coverage for some medical specialties. Tipton Hospital will continue to be the primary care hospital of Tipton area residents, while Methodist will offer special services to those who need care in a larger, more specialized hospital. Those services include a streamlined admission process, referrals to specialists as needed and regular reports to the patients' family doctors in Tipton. The affiliation also will help avoid unnecessary duplication of such services. ❑



Douglas Morrell, M.D., Rushville, answers questions during the public speaking session of the ISMA spokesperson training program.



Rajih Haddawi, M.D., left, Bloomington, and Robert Warren, M.D., Richmond, answer questions posed by Pat Clark, right, director, AMA Division of Issues Management, during a spokesperson training session held at the ISMA. Physicians who volunteered to serve as spokespersons in their communities on health system reform attended the session to improve their on-camera and public speaking skills.

obituaries

Mark M. Bevers, M.D.
Dr. Bevers, 47, a Seymour family physician, died Sept. 17.

He was a 1973 graduate of the Indiana University School of Medicine, where for 10 years he had been an associate professor of family practice.

Dr. Bevers had practiced in Seymour since 1974 and was the Jackson County coroner. He previously had been emergency room director at Jackson County Schneck Memorial Hospital and had served as president of the hospital medical staff. He was a member of the Indiana Coroner Association and a fellow of the American College of Family Physicians. Dr. Bevers had served the Indiana State Medical Association as a delegate and trustee.

William A. Clunie, M.D.
Dr. Clunie, 74, a retired Huntington otolaryngologist, died July 28.

He was a 1942 graduate of the Indiana University School of Medicine and served in the Army Medical Corps during World War II.

Dr. Clunie, formerly of Corydon, had lived in Huntington since 1951. He was a member of the Indiana Academy of Ophthalmology and Otolaryngology, the Huntington Rotary Club and the Huntington Veterans of Foreign Wars Post.

Warren C. Hastings, M.D.
Dr. Hastings, 79, a retired Fort Wayne neurosurgeon, died July 11 at his home.

He was a 1939 graduate of the University of Michigan Medical School and an Army veteran.

Dr. Hastings was the first neurosurgeon to practice in Fort Wayne, where he lived for 45 years. During his 32-year career in Fort Wayne, he practiced at Parkview Memorial and Lutheran hospitals and St. Joseph Medical Center. He was a past president of the medical board at Parkview Memorial and Lutheran hospitals and a founding member of the Congress of Neurological Surgeons.

Henry Leibundguth, M.D.
Dr. Leibundguth, 76, an Evansville orthopaedic surgeon, died July 24.

He was a 1942 graduate of Hahnemann University School of Medicine and was a captain in the Army, serving from 1943 to 1946 with the 251st Station Hospital.

Dr. Leibundguth co-founded the group now known as Tri-State Orthopaedic Surgeons in 1953. He had been a past president of St. Mary's Medical Center staff, a staff physician at Ellis Park and past treasurer for Mothers Against Drunk Drivers (MADD). He was a tutor at Impact Ministries and served on the board of directors of American Family Association.

Adoracion A. Marquinez Szkopiec, M.D.
Dr. Szkopiec, 72, a retired East Chicago anesthesiologist, died Sept. 19.

She was a 1946 graduate of the University of the Philippines College of Medicine.

Dr. Szkopiec had lived in East Chicago for the past 43 years and was a staff member at St. Catherine Hospital in East Chicago from 1958 until her retirement in 1985. She was a fellow of the American College of Anesthesiology.

Guido P. Wilhelm, M.D.
Dr. Wilhelm, 59, a New Castle obstetrician and gynecologist, died July 14.

He was a 1959 graduate of the University of Illinois College of Medicine.

Dr. Wilhelm was the first obstetrician and gynecologist in New Castle, establishing a practice there in 1963. He had been the school and team physician at New Castle Chrysler High School since 1972. Dr. Wilhelm had served as president of the Henry County Medical Society, the Henry County Memorial Hospital staff and the Henry County Health Department. He was a fellow of the American College of Obstetricians and Gynecologists and a member of the American College of Sports Medicine. An outdoor sports enthusiast, he had hiked in the Swiss Alps and ran the Boston Marathon three times. ❑



Dr. Feldman

Dr. Richard D. Feldman, director of the family practice residency program at St. Francis Hospital in Beech Grove, was appointed to the Medical Education Board by Gov. Evan Bayh. The board appropriates and develops policies for distribution of state money to residency programs.



Dr. Maxam

Dr. B.T. Maxam, a retired member of the medical staff of Methodist Hospital in Indianapolis, was elected chairman of the Methodist Health Foundation board of directors.



Dr. Overley

Dr. Toner M. Overley, an Indianapolis psychiatrist, was named medical director of the intensive outpatient eating disorders program at the St. Vincent Stress Center.



Dr. Kerner

Dr. Donald J. Kerner, an Indianapolis family practice physician, was appointed vice president of medical affairs at St. Francis Hospital in Beech Grove.

Dr. Stephen J. Jay, senior vice president of academic and medical affairs at Methodist Hospital in Indianapolis, is one of three editors of a recently published book titled *Evaluating Health Care Information Systems*. The book, which provides a guide for evaluating the impact of computerized information systems on the structure and function of health care organizations, may be ordered by calling Sage Publications, (805) 499-9774.

Activities of physicians from Nasser, Smith & Pinkerton Cardiology in Indianapolis include the following: **Dr. William K. Nasser** spoke on "Congenital Heart Disease in Adults" at the Sixth Annual International Cardiovascular Symposium" in Athens, Greece. **Dr. Cass A. Pinkerton** instructed physicians on the use of the new Cook Gianturoco-Roubin Flex Stent in Indianapolis; Columbus,

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

July

Behrend, Frank L., Valaparaiso
Billena, Raymundo L., Merrillville
Boen, Bradley N., Muncie
Fairchild, Thomas H., Indianapolis
Gard, Richard A., Kokomo
Ho, Chi-Yun, Greencastle
Hull, Joel I., Chesterton
Johnson, C. William, Indianapolis
Kaliney, William J., South Bend
Kays, Larry P., Evansville
LaSalle, Robert M., Wabash
Leipold, Jon D., South Bend
Lentz, William C., Fort Wayne
McCord, George E., Indianapolis
Montgomery, Ralph F., Muncie
Nixon, Christopher M., Peru
Novak, Joseph L., Fort Wayne
Ogle, Mark R., Carmel
Park, Jason Y., Terre Haute
Pearson, Huey L., Fort Wayne
Stanford, John R., Fort Wayne
Terpstra, William G., Noblesville
Torrella, Roxann M., Indianapolis

August

Andrews, Frederick B., Columbus
Bentz, John M., Fort Wayne
Bomba, Brad, Bloomington
Borhan, Manoochehr Z., Bedford
Braunlin, Robert J., Fort Wayne
Bushong, Rebecca L., Indianapolis
Cole, Larry G., Yorktown
Cottrell, Robert F., Fort Wayne
Cyran, Francis M., Auburn
Eastlund, Marvin E., Fort Wayne
Habermel, John F., Floyds Knobs
House, Jerry L., Indianapolis
Kissel, Wesley A., Bloomington
Moores, William B., Indianapolis
Nakamura, Takamitsu, Munster
Patel, Dineshchandra A., Munster
Rusher, Merrill W., Fort Wayne
Schauwecker, Donald S., Carmel
Schwartz, Jack, Munster
Schwartz, Magda, Hammond
Shabeeb, M. Nabil, Munster
Shoemaker, Robert E., Indianapolis
Smith, Anthony A., Kokomo
Smith, Darryl R., Fort Wayne
Stafford, Thomas M., Fort Wayne
Taylor, Millard R., Howe

people

Ohio; and Scottsdale, Ariz., and spoke on "Optimizing the Use of Short-Tipped Judkins Guides" and "Trouble-Shooting Coronary Stents-Rediscovering the 0.018 Coronary Guide Wire" at the the University of Alabama at Birmingham School of Medicine. **Dr. Bruce F. Waller** spoke to Indiana insurance underwriters on "Valvular Heart Disease in Older Agers – Is It Different Than the Young?" **Drs. Waller, Lawrence E. Gering, Nancy A. Branyas** and **John D. Slack** co-authored a paper on "Anatomy, Histology and Pathology of the Cardiac Conduction System – Part V" that was published in *Clinical Cardiology*.

Dr. Steven F. Isenberg of Indianapolis gave a poster presentation on "Fibrous Dysplasia of the Frontoethmoid Presenting as Pneumoencephalus: Endoscopic Approach to Diagnosis" at the annual meeting of the American Academy of Otolaryngology – Head and Neck Surgery in Minneapolis.

Dr. Clyde B. Kernek, an orthopaedic surgeon at the Indiana University Medical Center in Indianapolis, has published a book titled *Field Surgeon at Gettysburg*, a fictionally reconstructed memorial account of the medical unit of the Thirty-Second Massachusetts Regiment at Gettysburg in 1863. The book is available at Waldenbooks or by contacting Guild Press of Indiana, (317) 253-0097.

Dr. Richard W. Eaton, an Indianapolis orthopaedic surgeon, spoke to Swiss surgeons on "Modern Day Total Hip Arthroplasty: The State of the Art" in Zurich, Switzerland.

Dr. Stephen W. Perkins, an Indianapolis facial plastic and reconstructive surgeon, was a guest speaker at the fall meeting of the Greater Northwest Otolaryngology Association in Portland, Ore.; he presented seminars on transconjunctival blepharoplasty and chemical peel. Dr. Perkins lectured on chemical face peeling at the fall meeting of the American Academy of Facial Plastic and Reconstructive Surgery in Minneapolis.

Dr. Debra J. Myers, an Indianapolis pulmonary disease specialist, spoke on "Acute Respiratory Failure" at the National Medical Association Convention.

Drs. Morris E. Tilden and **Sherif I. Hanna** of Indianapolis were named to postdoctoral surgical fellowships at Corneal Consultants of Indiana for the 1993 academic year.

Dr. George A. Rowe, an Indianapolis surgeon, met with pediatric and general surgeons at the Charles University Hospital in Prague and the District Hospital in Pribram, the Czech Republic. The physicians discussed differences in the health care systems of the two countries and the needs of the Czech physicians.

Dr. Vidyasagar S. Tumuluri, an Indianapolis hand surgeon, was the top fund-raiser in the annual March of Dimes Walkathon for Healthier Babies; he raised more than $18,000 in pledges.

Dr. Jerry Kight of Indianapolis was named a fellow of the American College of Radiology.

Dr. Fred Dahling, a New Haven family practice physician, was appointed to a third two-year term on the Governor's Commission for a Drug-Free Indiana.

The Indiana Academy of Family Physicians presented several awards at its annual scientific assembly. **Dr. Kenneth E. Bobb** of Seymour received the Physician of the Year Award and is now eligible for the national award. He has practiced in Seymour since 1955. **Dr. William D. Carter**, associate director of the Memorial Family Practice Residency Program in South Bend, received the A. Alan Fischer Award in Medical Education. **Dr. James B. Johnson** of Greencastle received the Distinguished Public Service Award.

Dr. Perry F. Seal has retired after 47 years as a Brookville family physician.

Dr. James D. Rogge, an Indianapolis gastroenterologist, was named a member of the newly created state Assisted Suicide Issues Study Committee.

Dr. William G. Moore of LaPorte was elected president of the Indiana Chapter of the American College of Surgeons.

Dr. Gregory P. Barclay, a Jasper psychiatrist, was named medical director of Memorial Hospital and Health Care Center.

Dr. Betty Lou Walsman, a specialist in neonatal-perinatal medicine in Indianapolis, is helping raise money to provide medical equipment, beds and cribs for a 50-bed children's pavilion at Colentina Infectious Diseases Hospital in Bucharest, Romania. She is a member of the U.S. Medical Committee for the Colentina Hospital Project, set up by Children of the World.

Dr. C. William Hanke, a dermatologist at the Indiana University Medical Center, received the St. George Medal from the Indiana Division of the American Cancer Society.

Dr. Shaun D. Gunderson has retired after 30 years as a radiologist at Goshen General Hospital. He was the hospital's first full-time radiologist and helped to

develop the department. In his honor, the hospital's imagery center has been named the Shaun D. Gunderson Center.

Dr. Eugene M. Gillum has retired after 40 years as a Portland family physician.

Dr. Thomas W. McKain, a New Albany family physician, spent six weeks as a volunteer at a remote hospital in Kenya, Africa.

Dr. Edward F. Steinmetz, an Indianapolis cardiologist, was honored for professional achievement during the annual all-class reunion of Cathedral High School in Indianapolis.

New ISMA members

Robert E. Arnold, M.D., Salem, general surgery.

Chris R. Bahler, M.D., Kokomo, internal medicine.

Catherine L. Bain, M.D., Indianapolis, internal medicine.

Bradford J. Barrett, M.D., Richmond, general surgery.

Pedro S. Baula Jr., M.D., Connersville, pediatrics.

Victoria M. Baula, M.D., Connersville, pediatrics.

CarolMae M. Bosanko, M.D., Indianapolis, radiology.

Michael Brendle, M.D., Richmond, radiology.

Peter M. Britt, M.D., Indianapolis, radiology.

Jose A. Bufill, M.D., South Bend, oncology.

Kalen Carty-Kemker, M.D., Salem, family practice.

Dan M. Chaffee, M.D., Fort Wayne, emergency medicine.

Samuel E. Christen, M.D., Fort Wayne, ophthalmology.

Ellen B. Crowe, M.D., South Bend, family practice.

Timothy E. Dicke, M.D., Indianapolis, orthopaedic surgery.

Marc E. Duerden, M.D., Indianapolis, physical medicine and rehabilitation.

James E. Duncan, M.D., La Fontaine, anatomic/clinical pathology.

Gerry Easterday, M.D., Fremont, emergency medicine.

Katherine S. Edwards, M.D., South Bend, family practice.

Stephen P. Epperson, M.D., Richmond, family practice.

Ahmad Esmailbegui, D.O., Marion, emergency medicine.

Daniel M. Feinn, M.D., Fort Wayne, obstetrics and gynecology.

Robert J. Femia, M.D., Fort Wayne, emergency medicine.

Gary A. Frick, D.O., Marion, cardiovascular diseases.

Rhonda S. Ganansky, M.D., Evansville, dermatology.

Douglas D. Geiger, M.D., Bloomington, diagnostic radiology.

Steve L. Gerber, M.D., South Bend, ophthalmology.

Steven J. Goldstein, M.D., Sellersburg, internal medicine.

David W. Graybill, M.D., Anderson, orthopaedic surgery.

David B. Gudkese, M.D., Noblesville, diagnostic radiology.

Dale E. Guse, M.D., Columbus, family practice.

Ann M. Hake, M.D., Evansville, neurology.

Mark W. Harris, M.D., Evansville, emergency medicine.

Mark E. Hatfield, M.D., Columbus, cardiovascular diseases.

David W. Hollensbe, M.D., Indianapolis, urological surgery.

John A. Hudak, M.D., South Bend, urological surgery.

Melinda W. Hunnicutt, M.D., Columbus, cardiovascular diseases.

Margaret M. Inman, M.D., Indianapolis, general surgery.

Lillian S. Jardine, M.D., South Bend, family practice.

Cynthia L. Johnston, M.D, Indianapolis, family practice.

John P. Karagiannis, M.D., Elkhart, gastroenterology.

Danny P. Kaup, M.D., Valparaiso, emergency medicine.

Stephen E. Kemker, M.D., Salem, family practice.

Bruce E. Kinsey, M.D., Fort Wayne, anesthesiology.

Michael A. Kuharik, M.D., Carmel, diagnostic radiology.

Arvind Kumar, M.D., Richmond, radiation oncology.

Pankaj Kumar, M.D., Richmond, internal medicine.

James W. Lee, M.D., Evansville, oncology.

Glen E. Leer, D.O., Tipton, family practice.

Mark G. Lewis, D.O., South Bend, obstetrics and gynecology.

Randall P. LeDuc, M.D., Cincinnati, internal medicine.

Larry W. Lynn, M.D., Indianapolis, pediatrics.

Edwin L. McEowen, M.D., Fort Wayne, emergency medicine.

Martina G. McGowan, M.D., Elkhart, obstetrics and gynecology.

Janet S. Meckley, M.D., Richmond, family practice.

Charles H. Medberg, M.D., Fort Wayne, radiology.

John B. Meding, M.D., Mooresville, orthopaedic surgery.

Dennis P. Mishler, M.D., Elkhart, internal medicine.

Maximillian S. Newell, M.D., Indianapolis, otolaryngology.

John T. Nonweiler, M.D., Greencastle, family practice.

Jitendra I. Patel, M.D., Marion, internal medicine.

Yuchi P. Peng, M.D., Carmel, radiation oncology.

David J. Porter, M.D., Indianapolis, radiology.

Clifford E. Reske, M.D., Elwood, internal medicine.

people

Charlie E. Richardson, M.D., Fort Wayne, general surgery.

Christine M. Riley, M.D., Portage, internal medicine.

Keith E. Rockey, M.D., Marion, diagnostic radiology.

Russell B. Rothrock, M.D., Indianapolis, neurological surgery.

Thomas M. Rouse, M.D., Indianapolis, pediatric surgery.

Ricardo N. Sarli, M.D., Bloomington, anatomic/clinical pathology.

Usman A. Siddique, M.D., Lawrenceburg, neurology.

Timothy S. Smith, M.D., Indianapolis, radiology.

James R. Steinmetz, M.D., Richmond, urological surgery.

Vernon Taylor, M.D., Evansville, emergency medicine.

Jeb S. Teichman, M.D., Jeffersonville, pediatrics.

Andrew W. Tharp, M.D., Indianapolis, ophthalmology.

Patricia W. Tharp, M.D., Evansville, pediatrics.

Christine A. Tremper, M.D., Fort Wayne, radiology.

Margaret R. Troxell, D.O., Marion, family practice.

Janet K. Turkle, M.D., Indianapolis, plastic surgery.

Usha Vyas-Major, M.D., Valparaiso, emergency medicine.

Kevin L. Waltz, M.D., Indianapolis, ophthalmology.

Thomas A. Weinzapfel, M.D., Evansville, pediatrics.

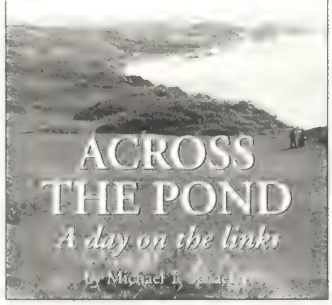
David L. Williams, M.D., Kokomo, family practice.

Gregg L. Zimmer, M.D., Fishers, otolaryngology. ❑

Correction

Daria Schooler, M.D., a Columbus neurological surgeon, is in her first year of private practice. She was identified as a resident in the new member list published in the September/October 1993 issue of INDIANA MEDICINE. ❑

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–George F. Peper, Editor, *Golf Magazine*

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CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS)

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin, the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life (t1/2) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin.* See WARNINGS, Skeletal Muscle.

Antipyrine. Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs. During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*; a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area ($mg/meter^2$). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS, **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated, adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy, this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below, also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug.

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitounnary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma, anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS, **Skeletal Muscle** and PRECAUTIONS, **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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THE PRAVACHOL® DIRECTION IN LIPID MANAGEMENT

Effective lipid management doesn't have to be tough



- Improves key lipids — significant reduction in LDL-C[1]
- Excellent safety profile
- Easy for patients — once-daily dosing, well tolerated
- Usual dose: 20 mg once daily at bedtime, with or without food

PRAVACHOL®

pravastatin sodium 20 mg tablets

PRAVACHOL is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

Active liver disease or unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin sodium.

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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